EXPANDING COVERAGE OF PRESCRIPTION DRUGS IN MEDICARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

APRIL 9, 2003

Serial No. 108–7

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

89–405 WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

BILL THOMAS, California, *Chairman*

PHILIP M. CRANE, Illinois
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHIL ENGLISH, Pennsylvania
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY C. HULSHOF, Missouri
SCOTT MCINNIS, Colorado
RON LEWIS, Kentucky
MARK FOLEY, Florida
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
ERIC CANTOR, Virginia

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
EARL POMEROY, North Dakota
MAX SANDLIN, Texas
STEPHANIE TUBBS JONES, Ohio

ALLISON H. GILES, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

EXPANDING COVERAGE OF PRESCRIPTION DRUGS IN MEDICARE

WEDNESDAY, APRIL 9, 2003

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 11:10 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 2, 2003
No. FC–7

CONTACT: (202) 225–1721

Thomas Announces Hearing on Expanding Coverage of Prescription Drugs in Medicare

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on modernizing Medicare and integrating prescription drugs into the program. **The hearing will take place on Wednesday, April 9, 2003, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Invited witnesses will include Dr. Douglas Holtz-Eakin, Director, Congressional Budget Office, and academics with extensive knowledge of prescription drugs and the Medicare program. Also, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

When Medicare was enacted in 1965, most health insurers did not cover prescription drugs. Since that time, most private health plans have fully integrated prescription drug coverage yet Medicare still does not cover most outpatient prescription drugs. Prescription drugs are now as important to health care as hospitals and physician services were 38 years ago.

Seniors are more likely to be faced with high out-of-pocket prescription drug costs than other individuals. While seniors comprise approximately 12 percent of the population, they consume nearly 40 percent of all prescription drugs. Yet nearly one-third of Medicare beneficiaries do not have some type of prescription drug coverage, and those without coverage often pay the highest prices for their medications. Further, many employers through their company retirement benefit plans are paring back or dropping prescription drug coverage as costs continue to dramatically escalate. Medigap plans with drug coverage are becoming increasingly unaffordable. Prescription drug costs are rising annually at double-digit rates. This causes seniors without coverage to often forgo necessary prescriptions, while jeopardizing current prescription drug coverage.

At the same time, Medicare's current costs are dramatically rising. For example, according to the Center for Medicare and Medicaid Services' Office of the Actuary, hospital costs were up by 10 percent last year. Likewise, skilled nursing home expenditures rose by 9 percent, home health spending increased by 14 percent, durable medical equipment spending increased by 20 percent, and hospice expenditures rose by 24 percent. These increased expenditures are partially borne by beneficiaries, whose Part B premiums are projected to rise by 12.4 percent next year.

Escalating Medicare spending in all areas means a new Medicare prescription benefit must be carefully designed to be affordable to both beneficiaries and taxpayers. In fact, all aspects of the program must be examined to discern where inefficiencies exist and changes need to be made.

In the last Congress, the House passed a Medicare prescription drug bill (H.R. 4954), but the Senate failed to act on the legislation. The President included $400 billion over 10 years in the fiscal year 2004 budget. The House and Senate passed

resolutions to include the same amount for prescription drugs, Medicare modernization, and appropriate adjustments to provider payments.

In announcing the hearing, Chairman Thomas stated, "The House passed Medicare modernization and prescription drug legislation in the 106th and 107th Congresses. It is clear that this Congress must make law."

FOCUS OF THE HEARING:

This hearing will focus on issues related to an outpatient prescription drug benefit for Medicare beneficiaries.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to hearingclerks.waysandmeans@mail.house.gov, along with a fax copy to (202) 225–2610, by the close of business, Wednesday, April 23, 2003. Those filing written statements that wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the full Committee in room 1102 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to hearingclerks.waysandmeans@mail.house.gov, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*** * * NOTICE—CHANGE IN TIME * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 4, 2003
No. FC–7–REV

CONTACT: (202) 225–3943

Change in Time for Hearing on Expanding Coverage of Prescription Drugs in Medicare

Congressman Bill Thomas (R–CA), Chairman, Committee on Ways and Means, today announced that the Committee hearing on modernizing Medicare and integrating prescription drugs into the program scheduled for Wednesday, April 9, 2003, at 10:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 11:00 a.m.**

All other details for the hearing remain the same. (See full Committee Advisory No. FC–7 dated April 2, 2003.)

Chairman THOMAS. The Chair considers this one of the more important hearings the full Committee will have as we consider how to modernize Medicare and, obviously, the importance of Medicare and the improvements it has made in millions of seniors' lives, especially as we notice that seniors are living longer and actually healthier lives than any generation in history. Although one of the reasons we are holding the hearing is because we think Medicare can do better. It really isn't 21st century-ready; it isn't even the last quarter of the 20th century-ready, because it doesn't provide a meaningful prescription drug coverage to seniors, who, coincidentally, are the largest group of consumers of the pharmaceuticals. In modern health care, prescription drugs are often the health care solution of choice. They prevent, treat, or manage diseases more effectively and less invasively than hospitals.

However, as we all know, Medicare provides extremely limited coverage for what are today vital medicines. That means the typical senior will spend about $1,450 out of pocket on prescription drugs this year. Unfortunately, notwithstanding that amount, seniors often pay the highest price because about a third of the seniors have no prescription drug coverage. However, as we all know, Medicare provides extremely limited coverage for what are today vital medicines. That means the typical senior will spend about $1,450 out of pocket on prescription drugs this year. Unfortunately, notwithstanding that amount, seniors often pay the highest price because about a third of the seniors have no prescription drug coverage.

Clearly something has to be done. Change cannot occur in a vacuum. You have to consider the context. This March, the Medicare trustees issued their annual report, which said that Medicare will start running deficits in about 10 years, and will go broke in 2026. This is complicated by the Congressional Budget Office's (CBO)

projection that annual spending on Medicare will more than double over the next 10 years, while spending on prescription drugs will triple.

Analysis by the Centers for Medicare & Medicaid Services (CMS) Actuary also shows that Medicare spending last year spiked. Hospital spending was up 10 percent; home health up 14 percent; skilled nursing facilities up 9 percent; durable medical equipment up 20 percent. All of these increases occurred with the backdrop of inflation at about 2.4 percent.

Integrating a prescription drug benefit to Medicare will clearly improve seniors' health and is long overdue. Hopefully, it can also reduce what would otherwise be Medicare's cost over time because we can substitute drugs as a more effective and less expensive alternative than some other treatment options. Also hopefully, we can integrate drugs around a disease management program that would provide a more comprehensive package for seniors when they are on multiple drugs, which is becoming more the pattern than not.

Steps must be taken when crafting the prescription drug benefit into other changes to ensure the sustainability of Medicare over the long haul. To simply take current Medicare and add prescription drugs is not the solution. The Medicare Payment Advisory Commission (MEDPAC), the non-partisan panel of experts that advise this Congress, has made a number of recommendations which would slow the growth of Medicare and which this Committee will examine very carefully.

History, and especially recent history, shows that we can deliver. In the last two Congresses, this Committee has produced, and the House has approved, legislation to modernize Medicare. As we know, those bills did not become law. They did not become law with a Democratic Senate and they did not become law with a Republican Senate. This year, the President has indicated he is willing to provide an additional $400 billion over 10 years to improve Medicare. The House and the Senate has passed a budget agreeing that that money would be utilized for Medicare.

We should not squander this opportunity to deliver prescription drugs for seniors while improving and strengthening Medicare for future generations. Shortly we will hear from the Director of the Congressional Budget Office, Dr. Douglas Holtz-Eakin, who I believe is in his first appearance in front of the Committee on Ways and Means, and David Walter, the Comptroller General of the General Accounting Office, who has been before us previously and who plays a significant role both in producing documents that assist us in making decisions and in making sure that those institutions which advise us are professionally structured and maintained.

Prior to doing that, I will recognize the Ranking Member from New York, Mr. Rangel, for any comments he would like to make.

[The opening statement of Chairman Thomas follows:]

Opening Statement of The Honorable Bill Thomas, Chairman, and a Representative in Congress from the State of California

As the Committee considers how to modernize Medicare, it's worth noting that since its inception Medicare has improved the lives of millions of our nation's seniors. Today, our seniors are living longer and healthier lives than any generation in history.

But we can do better. Medicare is not 21st century-ready. It does not provide prescription drug coverage to seniors—the largest consumers of pharmaceuticals.

In modern health care, prescription drugs are often the health care solution of choice. They prevent, treat or manage diseases more effectively and less invasively than hospitals.

However, Medicare provides extremely limited coverage for what are today vital medicines. That means the typical senior will spend about $1,450 out of pocket on prescription drugs this year. And unfortunately seniors often pay the highest prices because more than one-third of seniors have no prescription drug coverage.

But change can't occur in a vacuum; we must first consider the context. This March, the Medicare Trustees issued their annual report which said that Medicare will start running deficits in about ten years and will go broke in 2026. This is complicated by the Congressional Budget Office's projection that annual spending on Medicare will more than double over the next ten years, while spending on prescription drugs will triple.

Analysis by the Centers for Medicare and Medicaid Services Actuary also shows that Medicare spending last year spiked: hospital spending was up ten percent, home health up 14 percent, skilled nursing facilities up nine percent and durable medical equipment up 20 percent. And all of these increases occurred with a backdrop of inflation around 2.4 percent.

Integrating a prescription drug benefit to Medicare will clearly improve seniors' health and is long overdue. Hopefully it can also help reduce Medicare's costs over time because we can substitute drugs as a more effective and less expensive alternative to other treatment options. Integrating prescription drugs around disease management is important for seniors when they take multiple prescription drugs, which is happening more and more.

Steps must be taken when crafting the prescription benefit and other changes to ensure the sustainability of Medicare over the long haul. To take the current Medicare system and simply add on prescription drugs is not a solution. The Medicare Payment Advisory Commission, the non-partisan panel of experts that advises Congress, has made a number of recommendations to slow the growth of Medicare, which this Committee will examine very carefully.

History shows we can deliver. In the last two Congresses, this Committee has produced and the House has approved legislation to modernize Medicare. As we know, those bills did not become law. This year, the President recommended an additional $400 billion over ten years to improve Medicare. The House and Senate have passed budget resolutions providing for these resources. We should not squander this opportunity to deliver prescription drugs for seniors while improving and strengthening Medicare for future generations.

Mr. RANGEL. Thank you, Mr. Chairman, and thank you for bringing the Committee together on this most important subject matter. It has been almost a year since when we last visited it. I agree with you that this serious national issue demands and screams for some type of relief and solution, and everybody who campaigned, campaigned that they would do that. I do hope that you would agree, however, that this matter, there is no Democrat or Republican or presidential solution, that we should be working together. I understand that we have not been doing that. We have no bill, we have no direction.

We welcome a hearing from the witnesses, and I would like to yield to the Ranking Member on the Subcommittee on Health so that he can share with us what progress has been made by the Committee on this important subject. Mr. Stark.

Mr. STARK. Well, thank you, Mr. Rangel.

Mr. Chairman, thank you for holding this hearing. I notice from the comments today in the Congress Daily, that this hearing is to be the launch pad for getting started on a Medicare prescription drug benefit, that your approach will be comprehensive, dealing with Medicare as a whole and not just as a prescription drug benefit. I am hopeful that this morning we will hear more about what

you really mean. The answer to that question outlines, I think, the entire debate.

Are we going to move ahead to add a prescription drug benefit in Medicare in order to improve the Medicare program for seniors and people with disabilities, or will we use the allure of a prescription drug benefit as a tool to achieve fundamental restructuring—I would call it dismantling—of the Medicare program? Will the addition of long-overdue drug benefits come at the cost of ending Medicare as we know it, as an entitlement program that guarantees all seniors and people with disabilities access to the same set of benefits for the same costs? These are the questions that need to be answered.

I note that this hearing has no witness from the Administration. I would comment that the Energy and Commerce hearing yesterday, another hearing today, and a Joint Economic Committee hearing scheduled for tomorrow—no Administration witnesses. Now, I don't know if that is because they have refused to come, or they have not been invited. It leaves us all wondering what direction you plan to go, Mr. Chairman, with the Medicare prescription drug benefit. Are you going to proceed with a plan that is similar to that passed last year in the House, or will you take into account the policy the President has put forth? I think the American public, and especially America's seniors, would like to see that answered. Certainly, we on our side of the aisle would be better able to proceed in a bipartisan manner if we had some indication of what you had in mind.

Finally, I hope this is not the only hearing that we have prior to moving a Medicare bill through our Committee onto the House floor. Having a bill completed, as I know you want to, by the end of May is an ambitious agenda when the American public has never seen or been able to have any input in what you may plan to do. This is a program that covers 40 million lives and will cover many more than that before long. Change to this needs to be made in the open, and the seniors need to know what your plan will really mean for them.

So, once your plan is announced, I hope we will have more hearings that will allow representatives of the seniors organizations and others affected by the changes to come before our Committee and provide their counsel to this major change.

I look forward to hearing from the witnesses today and want to especially welcome Professor Uwe Reinhardt, who has come to share with us a bit of wisdom with regard to the Medicare reform. I thank the Chair again.

Chairman THOMAS. Thank the gentlemen. The Ranking Member of the Subcommittee on Health posed a number of questions, and to make sure that people don't think they were rhetorical, the Chair will respond briefly prior to recognizing the first panel.

The Ranking Member from New York indicated that all Members had taken a position on this issue during campaigns—therefore setting a clear political tone—but then indicated there were Democrat or Republican solutions. The Chair finds it interesting, then, that the Ranking Member of the Subcommittee, from California, indicated that before they could proceed in a bipartisan manner, they

needed the majority to commit to a partisan position so they could therefore react in a bipartisan way.

I tell the gentlemen that, just as in the last two Congresses, the plan that passes this Committee and will pass the House will be a Medicare plan under Medicare. The attempt to characterize the plans that have been passed as not under Medicare may in fact revert back to that campaign position that the gentleman from New York referred to. No plan has been offered and no plan has passed that does not come under Medicare. It is not outside of Medicare, it isn't a privatization; it is a Medicare program.

The reason we are holding a hearing is to try to ask basic questions, not to flak for any particular plan on either side of this dais. It is to inquire about the best estimate of cost of proposals that have been presented in the past, as a guide to helping us make decisions in the future. I think the panel will provide us with some basic understandings, so that as we begin to examine bills we have more of a common knowledge base in which to address the options that might be presented to us. The Chair believes that is the best way to pursue a program that has the best chance of not bankrupting Medicare, but providing prescription drugs for seniors.

With that, the Chair is once again pleased to recognize Dr. Holtz-Eakin, who is the new head of Congressional Budget Office, been in place for just a few months. I am sure that you have already fully appreciated the stress and cross-purposes for which that position was delightfully created. I am always amazed that people with brilliant academic backgrounds and successful work experience say yes to putting themselves in the kind of position that the Director of the Congressional Budget Office finds himself shortly after saying yes.

Also, to David Walker, who has a very difficult job in which Members ask the General Accounting Office to produce any number of documents, which are done in a timely fashion and in a scholarly way. If they don't conform to preconceived notions of what the report should have been, they aren't given the credence they should be. I have been pleased to say that, notwithstanding where the outcome of the research might fall, that the research itself has been impeccable. For that, I do want to compliment Mr. Walker. He, for this Committee, performs another service, and that is tends to oversee, as the landlord, the MEDPAC Commission, which is critical to assisting us in evaluating what is going on in the medical world so that we can make very difficult decisions across the broad spectrum of providers.

With that——

Mr. RANGEL. Mr. Chairman, would you yield——

Chairman THOMAS. Certainly.

Mr. RANGEL. For purposes of allowing me to join in welcoming our new Director. He brings a lot of credibility and prestige to this most important job. We look forward to working with you in a bipartisan way. Of course, I have always been a great supporter of U.S. General Accounting Office (GAO) and the great work that you do for the Congress and the country. We look forward to working with you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman very much for his comments.

Any written presentation you may have, gentlemen, will be made a part of the record, and you can address us in any way that you see fit in the time that you have available to you. These microphones are fifties era. The Chair hopes we will remodel this room soon. It has great ambiance, but we also need decent acoustics. So, if you will address directly into the mike, Members and the audience will have a chance to hear you. Dr. Holtz-Eakin.

[The opening statement of Mr. Ramstad follows:]

Opening Statement of The Honorable Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this important hearing on the critical issue of providing America's seniors with prescription drug coverage and Medicare's fiscal challenges.

As founder and co-chair of the House Medical Technology Caucus, I appreciate the incredible advances that medical technology and pharmaceuticals have made in recent years to treat and cure debilitating conditions. These advances are truly breathtaking and will become more and more prevalent as medical science continues to advance.

Unfortunately, the Medicare system penalizes seniors by incorporating these advances too late, if at all.

Congress needs to comprehensively reform Medicare to modernize the program and expand access to critical new technologies and drugs. By acting this year, we can improve health, save lives and save the system money.

The question is how to maintain the standard of care enjoyed by America's seniors, improve the system and meet the incredible demographic challenges facing us. This is not a simple task, and a prescription drug benefit will place new pressure on Medicare as our nation's senior population grows.

With the President and Congress committing to invest $400 billion over the next ten years on Medicare reform and a prescription drug benefit, the time to act is now. Our seniors have waited too long.

At the same time, we must ensure the long-term stability of the Medicare system so that it is vibrant for both current and future beneficiaries. To that end, we must examine the fiscal implications of our actions, and examine ways to prevent wasteful spending while ensuring the highest quality of care for our seniors.

Thank you again, Mr. Chairman, for holding this important hearing.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. HOLTZ-EAKIN. Well, thank you, Mr. Chairman, thank you, Mr. Rangel, both, for the chance to be here and for the gracious welcome. I really do appreciate it and look forward to working with you.

You have my written testimony. Let me take my time and pull out what I think are key facts that may be of some use to the Committee in thinking about the issues that face us today.

One message that I hope comes through clearly is that the entitlement programs of Medicare, Medicaid, and Social Security, as currently structured, are on a trajectory to overwhelm the Federal budget. Currently, these three programs constitute 8 percent of gross domestic product (GDP). By the year 2030, they will rise to 14 percent of GDP—a bit under the size of the Federal budget at the moment; and by the year 2075, they will rise to fully 21 percent of GDP, a share larger than that of the Federal budget.

Medicare is the largest part of that rise. The chart that we have pulled out of the testimony to display shows this rapid rise in Medicare as a fraction of GDP from 2.4 percent today to about 9.2 percent in 2075. As you can see on the chart, that rise comes in

two different components. The first is a component that just is due to the aging-of-the-population phenomenon, with which you are quite familiar. That is a smaller component, about 30 percent of the overall increase. The larger component comes from the rapid rise in health care costs above the growth in GDP. That excess cost growth is not unique to Medicare, but is at the source of the large run-up in this entitlement program as a fraction of GDP.

Now, if we turn to cost growth in Medicare per se, CBO projects that over the next 10 years in the budget window, Medicare will continue to grow faster than GDP, at about 6.8 percent per year. As we detailed in the testimony, there are limited direct tools at the Congress' disposal to control that growth. It is a phenomenon that exists not only in Medicare, but in the health care area as a whole.

Now, for the purpose of this hearing, an interesting piece of information is the growth in prescription drug spending. On that front, there is both good news and bad news. CBO's baseline projections for prescription drug spending by the Medicare population indicate that the good news is that spending in the baseline is up by only 4 percent from last year. Typically, one might expect a larger increase in baseline spending. The 4-percent increase comes from the net effect of dropping a relatively inexpensive year at the beginning of the budget window and adding a relatively expensive year at the end of the budget window—that is the typical story. This year, we also learned, after looking into the research, that we had less underreporting of prescription drug spending than had previously been thought and slower growth in prescription drug prices than had been anticipated.

The net effect of that is a modest increase in our baseline estimates of prescription drug spending by this population, making it easier to compare cost proposals. Although they won't all be 4 percent higher—it depends on the details of the proposals—it does make year-to-year comparisons a bit easier, perhaps, than in the past.

Now, the bad news is that prescription drug spending continues to rise faster even than overall Medicare spending itself. We project that over the 10-year budget horizon, it will rise by 9 percent per year, for a total of $1.8 trillion.

The final piece that I would like to pull out of the testimony is the composition of some of that prescription drug spending. For purposes of this hearing, we put together three charts, the first of which shows who is covered by drug coverage at the moment and who is not. If you look at the chart, what the bars show you are the coverage for different income levels, each measured as a fraction of the poverty level, so the first bar is from 0 to 100 percent of the Federal poverty level and the others rise to 400 percent of the poverty level or more. Shown in the chart are lighter gray areas, which are the fraction of beneficiaries in each income area who do not have drug coverage, and darker gray shading, for those who do have drug coverage. Roughly speaking, the population as a whole has about a 25 percent share, in our estimate, that does not have prescription drug coverage, and the share does not vary much by income class—from 22 percent to 32 percent.

If we turn from who has coverage to how much individuals are spending, we get roughly the same story. The second chart looks at average prescription drug spending by Medicare beneficiaries. The bottom lighter gray area shows how much is paid out of pocket—about three-eighths is paid out of pocket—and that share does not vary much by income. The top darker gray part shows the share paid by third parties, including other Federal programs. The average spending is about $1,500.

If you put those two pieces together, coverage and average spending by individuals, we can show the total spending, in the final chart, for the Medicare population. Here, again, we can find total drug spending by income class, with the lighter gray area showing the fraction that is actually paid out of pocket—and that turns out to be roughly the three-eighths I mentioned before—and the darker gray area, which has been covered by third parties already. The basic message, again, in this chart is that there is not much difference across income levels in the degree to which these costs come from out of pocket.

So, I close with these pieces of information, which we think will be useful in framing the important issues that this Committee will face. I look forward to answering your questions.

[The prepared statement of Dr. Holtz-Eakin follows:]

Statement of Douglas Holtz-Eakin, Ph.D., Director, Congressional Budget Office

Chairman Thomas, Congressman Rangel, and Members of the Committee, I am pleased to be here with you today. I understand that the focus of this hearing is on expanding Medicare's coverage of prescription drugs, and I am prepared to discuss that topic in some detail. But I would first like to frame that discussion by looking at Medicare's overall financial picture, both in the near term and the long run. As this Committee well knows, Medicare is projected to consume an ever-larger piece of our national income just in delivering its current set of benefits. In determining whether and how to add prescription drug coverage to its benefit package—and the desirability of adopting other reforms to the program at the same time—lawmakers will face the challenge of balancing the needs of beneficiaries against the resulting pressures on the economy. To assist in that effort, I will describe the Congressional Budget Office's (CBO's) latest projections of prescription drug coverage and of drug spending for the Medicare population. I will then conclude my testimony by outlining some of the key issues that arise in designing a prescription drug benefit for Medicare.

Factors Driving Medicare Spending

Under current law, Medicare spending—measured as a share of the economy—is projected to nearly quadruple by 2075, growing to more than 9 percent of gross domestic product (GDP) from its current level of 2.5 percent. As a consequence, Medicare will necessarily compete with other spending priorities for a much greater share of the Federal budget or with private-sector spending for a bigger share of the national economy—or with both. In thinking about how to address the substantial challenges that the Medicare program faces, however, it is important to recognize that they are not unique to Medicare; rather, they reflect the broader forces of an aging society, the rising costs of health care generally, and the looming long-range financial strains that will affect the Federal Government and the economy as a whole.

Clearly, part of the challenge facing Medicare stems from the demographic trends that are making the country as a whole older. From 1970 to 2010, the number of Americans ages 20 to 64 is projected to increase by nearly 80 million; the elderly population by 2010 will have grown by about 20 million, or roughly one-fourth as much. In contrast, for the period 2010 to 2030—when the baby-boom generation will retire—the number of working-age individuals is projected to grow by about 10 million, whereas the population ages 65 and older will increase by 30 million, or three times as much. The consequence of those diverging patterns is that the ratio of the elderly population to the population in its prime working years—which stood at 19

percent in 1970—is projected to grow from 21 percent today to 35 percent by 2030. The ratio is then expected to continue to climb (albeit at a slower rate) and could reach 42 percent in 2075. In other words, the shift to an older society will accelerate as the baby-boom generation retires, and it will persist afterwards, making the changes that the nation faces—and their implications for the spectrum of Federal tax and spending policies—more than just temporary.

Compounding those demographic pressures are the seemingly inexorable increases in health costs per person—but that issue, too, is not limited to Medicare. Nationally, health care expenditures as a percentage of GDP have more than doubled over the past several decades, growing from 7.0 percent in 1970 to 14.8 percent in 2002. On a per capita basis, national spending for health care (in 2002 dollars) increased from $1,321 in 1970 to $5,366 in 2002, or at an average rate of about 4.5 percent per year—which is about 2.4 percentage points faster than the growth of the underlying economy. The factors contributing to the trend in real (inflation-adjusted) per capita health care spending include expansions in insurance coverage, rising income, medical price inflation in excess of general inflation, and the aging of the population—but the major impetus has been the development and diffusion of new medical technology. At the same time, it should be noted that improvements in that technology—while costly—have increased the health care system's potential to deliver high-quality care. If the adoption of new technology is driven by the needs of patients, the value of those improvements may well exceed their cost.

Over the 1970–2002 period, Medicare spending has risen even more rapidly than national health expenditures, growing eightfold even after adjusting for inflation. As a share of GDP, Medicare costs rose from 0.7 percent in 1970 to their current level of 2.5 percent. Although cost growth on a per-enrollee basis has been volatile, it has also tended to rise at a much faster pace than the economy has grown. Over the period, real costs per enrollee grew more than twice as fast as the economy—specifically, at the rate of per capita GDP plus 2.8 percentage points. One reason that total Medicare costs have grown more quickly than overall health costs is that the number of beneficiaries has grown more quickly than the U.S. population as a whole, owing both to program expansions and to the increase in the share of Americans who are elderly. In terms of costs per beneficiary, the growth of Medicare spending is due in part to the same factors that have driven increases in health care spending nationally, but it also reflects legislative and administrative expansions of the program's benefit package.

In general, precisely determining each factor's effect on overall program spending is difficult. As an illustration, however, consider spending for services provided to fee-for-service program enrollees during acute care hospital stays (which now account for about one-third of Medicare's total costs). The program's total spending for those services grew by 261 percent between 1972 and 1998, after adjusting for general inflation (see Table 1). That growth in total spending is the product of three factors: increases in the number of Medicare beneficiaries; increases in the number of hospital admissions per beneficiary; and—the most important factor—increases in the real cost per admission. That cost nearly doubled over the period in real terms and accounted for 57.4 percent of the overall growth. Over the same period, the number of enrollees in the fee-for-service program increased by about 50 percent, contributing 30.3 percent of the rise in spending. The number of hospital admissions per beneficiary grew more slowly and accounted for only 12.3 percent of the increase in total costs.

Table 1.—Sources of Fee-for-Service Medicare Cost Growth for Acute Care Hospital Services

	1972	1998	Percentage Increase, 1972–1998	Percentage Share of Total Increase
Total Costs (Millions of dollars)	21,744	78,522	261.1	100.0
Number of Beneficiaries (Millions)	21.1	32.0	51.3	30.3
Admissions per Beneficiary	0.302	0.365	20.9	12.3
Cost per Admission (Dollars)	3,408	6,724	97.3	57.4

Source: Congressional Budget Office based on Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 2000*.

Note: The costs noted in the table (which are in 1998 dollars) reflect inpatient costs for fee-for-service enrollees at acute care hospitals.

One valuable feature of such a breakdown is that it highlights the factors driving Medicare spending that lawmakers can influence and those that they cannot. In this case, costs per admission reflect the mix of, and prices for, therapies or services provided in an average admission. Today, policymakers can directly control only one of those two components: the price paid for a given service, which is updated annually as specified by statute. Thus, for example, lawmakers can seek to change the increase in payments for procedures such as a coronary artery bypass graft, but they do not control the share of total admissions accounted for by each procedure—which results from decisions made by doctors and their patients. The payment systems that are established in law do influence how doctors and other health care providers make treatment decisions. Similarly, features such as the cost sharing for those services can affect what beneficiaries choose to do. But the impact of changes in policy on those individual decisions is complicated and far from direct.

CBO's Projections of Medicare Spending Under Current Law

With that historical view in mind, let me turn now to CBO's projections of Medicare spending for the next 10 years, which were updated in March. CBO projects that gross outlays for Medicare benefits will total $271 billion in 2003 and $3.9 trillion over the 2004–2013 period (see Table 2). As a share of the economy, those Medicare outlays are projected to rise from 2.5 percent in 2003 to 2.9 percent in 2013, on average constituting 2.7 percent of GDP over the 2004–2013 period. After deducting projected premium payments by beneficiaries—which amount to $28 billion in 2003 and $461 billion over the 10-year period—CBO estimates that net spending for Medicare benefits will total $243 billion in 2003 and $3.4 trillion from 2004 through 2013. All of CBO's projections reflect the assumption that current law remains unchanged, thereby establishing the "baseline" for legislative proposals.

Focusing on the program's growth rates, CBO projects that net spending for Medicare benefits will increase by 5.9 percent in 2003 and will grow at an average annual rate of 6.8 percent over the 2004–2013 period. In recent years, the annual rate of growth of Medicare spending has varied considerably. Growth averaged 1.2 percent annually during the 1997–2000 period but has averaged more than 8 percent since then. Spending for benefits provided under Part B of Medicare (Supplementary Medical Insurance) grew particularly rapidly in 2002, driven by a significant rise in the volume and intensity of physician services and by increases of about 20 percent in spending for durable medical equipment and physician-administered pharmaceuticals. Costs for Part A of Medicare (Hospital Insurance) also rose sharply, including a 10 percent increase in spending for inpatient hospital services.

Table 2.—Summary of CBO's March 2003 Baseline Projections of Medicare Benefit Outlays

(By fiscal year)

	Billions of Dollars		Average Annual Rate of Growth, 2004–2013 (Percent)
	2003	2004–2013	
Gross Benefit Outlays	271	3,880	6.9
Premiums	–28	–461	8.2
Net Benefit Outlays	243	3,419	6.8

Source: Congressional Budget Office.

a. Outlays exclude spending by Medicare for quality improvement organizations, health care fraud and abuse control, and other administrative costs. Total spending on those activities is projected to be $5.4 billion in 2003. Of that amount, $3.8 billion is subject to appropriation.

The projected growth rates of Medicare's payments vary by service type. Total payments to hospitals for inpatient services and payments to physicians, which together account for two-thirds of the program's outlays, are the slowest-growing components of spending for fee-for-service enrollees, respectively averaging 6.4 percent and 5.9 percent annually in CBO's baseline projections through 2013. By contrast, rates of growth for the costs of other services—for example, those provided by home health agencies and non-physician professionals—are projected to average 10 percent to 13 percent annually (but will still constitute a relatively small share of total Medicare spending).

Over the next decade, CBO expects several factors to play a major role in the program's cost growth. Those factors include rising levels of enrollment in Medicare and automatic increases in payment rates for many services in the fee-for-service program (to adjust rates for rising input costs). CBO also projects changes in the

use of Medicare's services, reflecting an increase in the number of services furnished per enrollee as well as a shift in the mix of services toward those that are higher priced and (often) more technologically advanced. In part offsetting the effects of those spending components on total costs will be small or negative updates (adjustments) to payment rates for physician services and smaller updates (relative to cost increases in the fee-for-service program) to the rates paid to Medicare+Choice plans.

Specifically, increases in payment rates account for about 45 percent of the projected rise in Medicare spending over the next decade; the other 55 percent is equally divided between increases in enrollment and changes in the quantity and mix of services delivered per beneficiary. As noted above, payment rates are the easiest factor for policymakers to control. Rates for many services are automatically adjusted for rising input costs. In the past, legislation has frequently limited those increases to less than the full change estimated for those costs. Since 1990, for example, updates to payment rates for hospital admissions have averaged about 1 percentage point less than the increase in the market-basket index used to measure increases in the cost of hospital inputs. Under current law, however, payment rates for services furnished by hospitals and many other providers will automatically rise by the full amount of the increase in estimated input costs, as a result of the expiration of many of the provisions contained in the 1997 Balanced Budget Act.

Medicare's payment rates for physician services are subject to a very different update formula. Most recently, the Balanced Budget Act established an ongoing target for cumulative spending for physician services (and services that accompany physician visits). By statute, that target is automatically adjusted each year for changes in physicians' input costs and in the program's enrollment—plus the change in GDP per capita. (Future effects of enacted legislation and of regulation are also taken into account.) In the absence of per capita GDP growth, the real (inflation-adjusted) target for spending per enrollee remains unchanged. Increases in GDP per capita thus act as an allowance to cover increases in the number and average cost of services being furnished per enrollee as technology and medical practices evolve over time. If total spending for physicians deviates from that allowance—in either direction—then the annual updates to payment rates are adjusted over a period of several years to bring cumulative spending back in line with the target.

By the time payment rates were set for 2002, expenditures for physician services had exceeded the cumulative target, so rates for those services were reduced by about 5 percent, and a further reduction of 4.4 percent was originally scheduled for 2003. However, the Department of Health and Human Services invoked a provision of the 2003 Consolidated Appropriations Resolution to increase the cumulative target for 2002. As a result, payment rates for physician services in 2003 were increased by 1.6 percent.

Nevertheless, CBO projects that spending for physician services will again exceed the target in 2003 and remain above it on a cumulative basis through 2013. Therefore, in the absence of further legislative action, payment rates for those services are likely to decline (in absolute terms) for the next several years. (For example, last month the Centers for Medicare and Medicaid Services released a very preliminary estimate of the physician fee schedule update for calendar year 2004 indicating that payment rates could be cut by 4.2 percent.) At the same time, the total volume of services provided will continue to rise as the number of beneficiaries increases and the number of services provided per beneficiary grows. As a result, CBO projects that total Medicare spending for physician services—which is the product of the prices paid and quantities used for the mix of services provided—will rise each year through 2013, on both an aggregate and a per capita basis. I should reiterate here that those projections reflect CBO's best estimate of what will occur under the assumption that no changes are made in current law; in the past, lawmakers have often acted to modify those payments, whether to correct discrepancies between payment rates and the costs providers incur or for other purposes.

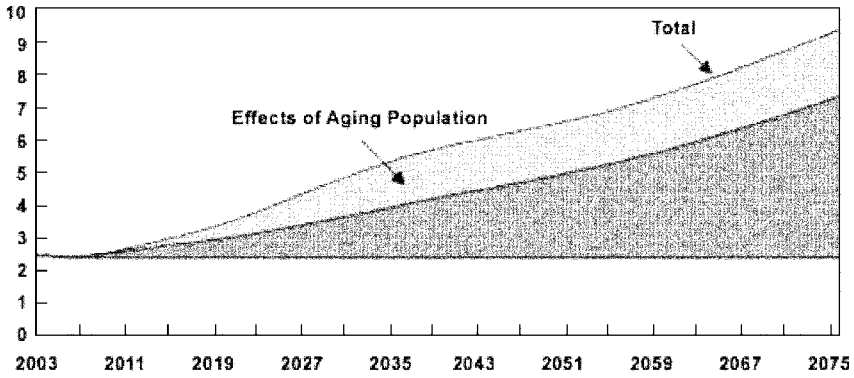
Medicare's Long-Term Financing Challenges

Although the 10-year budget window for Medicare now includes enrollment of the first wave of the baby-boom generation—those individuals born between 1946 and 1948, who will turn 65 by 2013—a complete picture of the program's fiscal outlook requires an even longer view. Toward that end, CBO projected the cost of Medicare as a share of GDP out to 2075 to show how much of the country's production of goods and services would be needed to pay for the program as it is currently structured. Although we are continuing to refine our projection models, CBO currently estimates that Medicare's costs as a percentage of GDP will rise from 2.5 percent in 2003 to 9.2 percent in 2075. Approximately 30 percent of that growth is due to society's aging and the resulting increase in the number of Medicare beneficiaries;

the remaining 70 percent is attributable to the growth of health care costs per enrollee in excess of the rate of growth of GDP per capita (see Figure 1).

For a sense of the magnitudes involved, if the Medicare program's costs accounted for 9.2 percent of GDP today, they would equal half of what is now spent by the entire Federal Government. If the program's higher costs were simply added to current Federal spending, total Federal receipts (which currently absorb about 18 percent of GDP) would have to be one-third larger to balance the budget. And if those increased costs were paid for entirely through a payroll-based tax, the rate for Social Security and Medicare, now set at 15.3 percent on the earnings of most workers, would have to more than double—a rise equal to roughly $6,000 per worker (that is, $3,000 each for the worker and his or her employer).

Figure 1.—Projected Long-Term Growth of Medicare Spending (Percentage of GDP)



Source: Congressional Budget Office.

Of course, the fiscal challenges facing Medicare will occur in parallel with those for Social Security and Medicaid. Those three programs now absorb 8 percent of GDP, but if CBO's projections hold, that figure will rise to 14 percent by 2030. Beyond that point, spending pressures will only intensify, with life expectancy continuing to increase and health costs continuing to grow. CBO projects that by 2075, the cost of the three programs could climb to 21 percent of GDP, the largest portion of which would be attributable to Medicare. To accommodate the increase in spending, either taxes would need to be raised dramatically or spending on other Federal programs would have to be curtailed severely—or Federal borrowing would soar.

For Medicare, the most significant factor affecting those projections is that annual growth of spending per beneficiary is expected to increase faster than per capita GDP growth—but much less quickly than in the past. CBO's current projection assumes that per capita Medicare spending will eventually grow 1 percentage point faster than per capita GDP, a rate that is substantially slower than the 2.8 percentage-point "excess cost" rate that the program has experienced over the past 32 years (part of which has been due to program expansions). CBO's assumption of an eventual deceleration in the relative rise of health care costs is consistent with that of the Medicare trustees (as well as others) and reflects the view that forces within the health care sector will operate to slow the rate of growth somewhat.

But that assumption might be too optimistic, and even seemingly small deviations from it could have significant economic implications when costs are projected over long periods. For example, if the growth of per capita Medicare costs slowed only to the rate of per capita GDP growth plus 1.5 percentage points, then program outlays would equal 5.4 percent of GDP in 2030 and 13.2 percent in 2075 (and if the health sector as a whole grew at that rate, it would account for more than half of the economy's output by 2075). Adding to the uncertainty is the potential for program expansions, because enacting a new prescription drug benefit or easing existing limits on payments to providers could exacerbate the rising long-term spending trajectory.

Prescription Drug Coverage and Spending

I would now like to describe CBO's latest projections of prescription drug coverage and spending for the Medicare population under current law. I offer them not just because they serve as the basis for our estimates of legislative proposals to add a

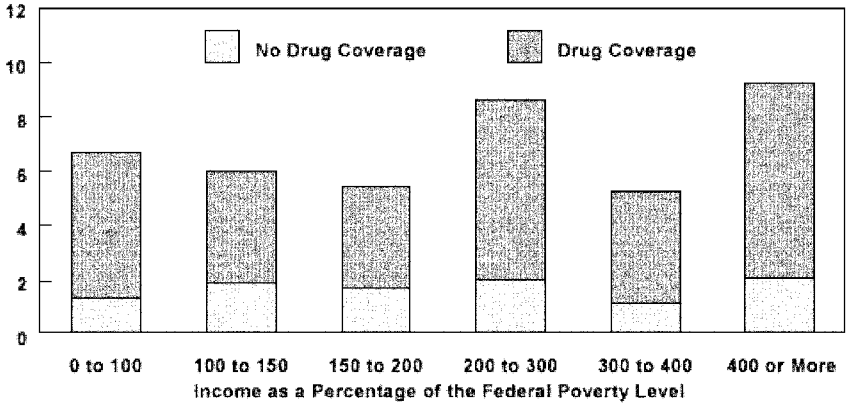
drug benefit to Medicare but also because they may provide useful insights for the design of such proposals.

Most Medicare beneficiaries now have coverage for prescription drugs at some point in the year, but the extent of that coverage varies widely. CBO's analysis of the Medicare Current Beneficiary Survey indicates that in 2000 (the most recent year for which data are available), 75 percent of the Medicare population—or roughly 30 million individuals—had some form of insurance coverage for the costs of prescription drugs for at least part of the year; 25 percent—or roughly 10 million beneficiaries—had no drug coverage. Beneficiaries who have coverage for their drug costs obtain it from a variety of sources. For example, nearly 30 percent of Medicare beneficiaries obtained coverage through employer-sponsored retiree benefits, and another 16 percent had coverage through the Medicaid program. About 12 percent of beneficiaries are estimated to have had drug coverage through individually purchased Medigap policies, while the remainder obtained coverage through a Medicare+Choice plan or from another State or Federal program.

CBO's estimates of the total number of Medicare beneficiaries grouped by income and the share of them who lacked drug coverage throughout 2000 appear in Figure 2. Although the fraction of beneficiaries without coverage varied from 32 percent (for those with income between 100 percent and 150 percent of the Federal poverty level) to 22 percent (for those with income exceeding 400 percent of poverty), CBO's main finding is that the differences across the income spectrum are not dramatic. The varying degrees of coverage are likely to reflect both difficulties in obtaining private drug coverage as well as rational "nonpurchase" of such coverage by beneficiaries with low levels of drug spending.

Clearly, the extent of the drug coverage that Medicare beneficiaries have today—and whether and how that coverage should be added to Medicare—is of central interest to policymakers, for two reasons: the elderly and disabled as a group use substantial amounts of prescription drugs, and their spending for such drugs has been rising rapidly in recent years. CBO's analysis indicates that Medicare beneficiaries bought about $1,500 worth of drugs, on average, in 2000 and that more than 90 percent of beneficiaries filled at least one prescription that year. Overall, about three-eighths of those costs were paid out of pocket, a figure that combines the payments of those without coverage (who pay the full cost of their drugs) and those with coverage (who incur copayments and deductibles). When average drug spending and out-of-pocket costs for Medicare beneficiaries are broken down by beneficiaries' level of income, again, the main finding is that average spending—both total and out-of-pocket—is remarkably similar for all income groups (see Figure 3).

Figure 2.—Medicare Beneficiaries in 2000, by Income Level and Drug Coverage
(Millions of beneficiaries)

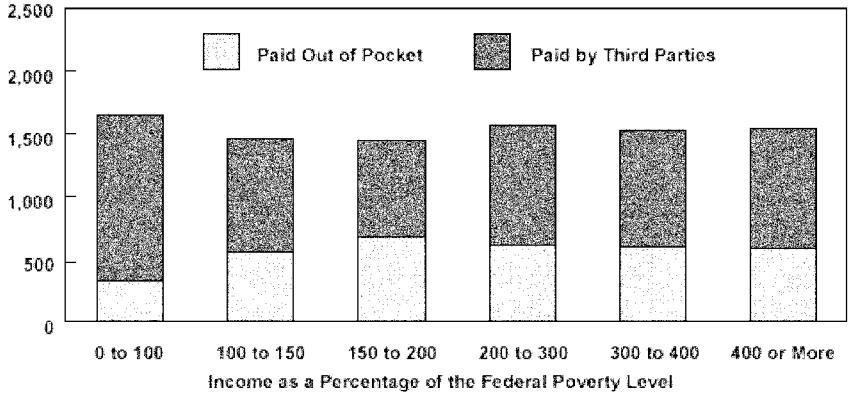


Source: Congressional Budget Office.

As Figure 4 indicates (see page 12), an important consideration in designing any Medicare drug benefit is how it will affect the out-of-pocket costs of enrollees as well as the large amount of payments currently made by third parties (including other Federal programs). For example, in 2000, the 8.5 million Medicare beneficiaries with income between 200 percent and 300 percent of the poverty level used about

$13 billion worth of drugs. Beneficiaries paid about $5 billion of that cost directly, and $8 billion was paid on their behalf. (Beneficiaries ultimately pay part of those covered costs if they pay a premium for their coverage.)

Figure 3.—Average Prescription Drug Spending in 2000 by and for Medicare Beneficiaries
(Dollars)



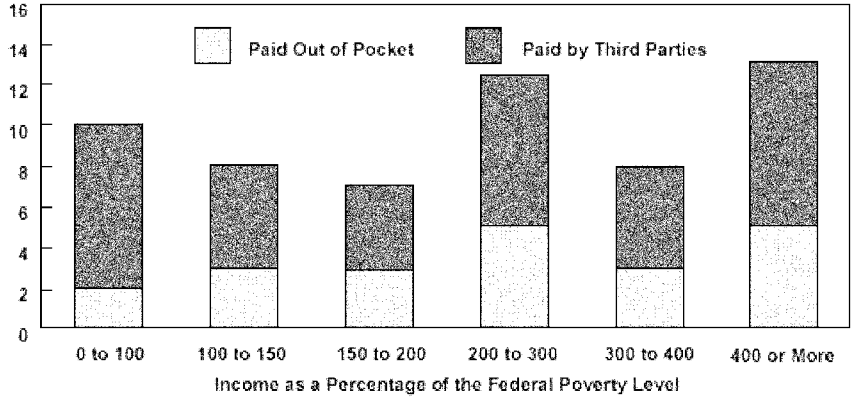
Source: Congressional Budget Office.

CBO's Projections of Future Drug Spending

As the above data illustrate, elderly and disabled Medicare beneficiaries now consume substantial amounts of drugs. In addition, their spending is projected to continue growing at a rapid pace (as is drug spending for the country as a whole). For the period 2004 through 2013, CBO estimates that spending for prescription drugs by and on behalf of the Medicare population will total roughly $1.8 trillion, or nearly 50 percent of the projected $3.9 trillion in Medicare outlays over that same period. Over that period, CBO expects Medicare beneficiaries' average spending for prescription drugs to climb quickly—at an average annual rate of about 9 percent—even in the absence of a Medicare drug benefit.

CBO's current estimate of total drug spending is about 4 percent higher than its projection last year for the 2003–2012 period. Typically, shifting the projection period forward by one year adds a relatively expensive year and drops a relatively inexpensive one, leading to a larger increase. This year's estimate, however, reflects two offsetting factors: new information about the degree to which drug spending is underreported in current surveys (which slightly lowered the starting point for the projections); and somewhat lower projections of the rate of growth of drug spending (the result, in part, of slower-than-expected economic growth in the near term).

Figure 4.—Total Prescription Drug Spending in 2000 by and for Medicare Beneficiaries
(Billions of dollars)



Source: Congressional Budget Office.

Issues in Designing a Drug Benefit

The financial challenges already facing the Medicare program and the significant sums that projections indicate its beneficiaries will spend on drugs combine to make designing a drug benefit for that program a formidable task. In considering how to design such a benefit, it is useful to begin with some key principles of insurance design that—as an economist—help me think through the complex issues involved and are related to some of the options with which the Congress is now grappling.

The first and foremost issue to confront is the structure of the benefit that is provided—that is, the deductible and cost sharing it will require. In general, well-designed insurance should reduce the risk of catastrophic financial losses yet leave individuals to cover their routine, expected expenditures with their own resources. Such a design would also reflect concern about the phenomenon known as "moral hazard"—in which further coverage would induce additional and perhaps excessive demand for services.

Applying that principle would suggest that Medicare's drug benefit should focus on protecting beneficiaries against very high drug costs. If Medicare adopted some kind of catastrophic approach, most enrollees would receive no payments in any given year, but they would nonetheless benefit from being protected against the possibility of catastrophic expenses. Several factors related to the nature of drug spending, however, complicate the application of a "pure insurance" approach. The two most important factors are the degree to which the distribution of drug spending is skewed and the degree to which it is persistent.

Concentration and Persistence of Drug Spending

Although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated among a much smaller group. In 2000, about 26 percent of enrollees had expenditures of $2,000 or more, and together they accounted for 65 percent of total drug spending by the Medicare population. At the same time, 32 percent of beneficiaries had expenditures of $500 or less, making up about 4 percent of total spending.

Of course, skewed annual expenses by themselves are actually typical of insurance markets, since insurance is usually purchased to protect against a small but relatively random risk of a large loss. What makes insurance for drug coverage difficult to provide is that prescription drug costs persist over time for the same enrollees. In particular, a large share of drug spending is associated with treatment of chronic conditions—such as hypertension, cardiovascular disease, and diabetes—which are often evident by the time individuals become eligible for Medicare. The result is that potential enrollees have important "private information" about their future drug costs. That fact makes stand-alone drug coverage particularly susceptible to adverse selection, in which enrollment is concentrated among those who expect to receive the most in benefits.

Indeed, those same facts help explain why beneficiaries may find it difficult today to purchase private coverage for prescription drugs—or why catastrophic protection

is virtually unavailable except through subsidized retiree coverage or Medicaid. If beneficiaries were given a choice about whether and when to purchase individual prescription drug coverage, people with high drug costs would be most likely to participate. That would drive premiums up, which in turn would reduce enrollment as enrollees with below-average drug costs dropped out. In the extreme, that spiral could lead to a market failure in which no insurance was sold, even if most people would be willing to pay more than the average cost of a policy that had broad enrollment. Those theoretical pressures are well illustrated in practice by today's market for new Medigap policies that include a drug benefit (which cover as much as half of an enrollee's drug costs but cap the benefit at $1,250 or $3,000 per year). Insurers that offer such policies often charge a premium that represents a very large share of the maximum potential drug benefit—to reflect the average cost of their enrollees. Similarly, the drug coverage available through Medicare+Choice plans is generally subject to caps.

Most proposals for a Medicare drug benefit have sought to correct for such market failures by including coverage for catastrophic drug costs but, accordingly, must also include measures designed to avoid an adverse selection spiral. One potential approach would be to make enrollment mandatory. A related option would integrate drug coverage into the benefit package for Part B of Medicare (and charge a correspondingly higher premium), so that beneficiaries could not separate their choice of whether to obtain drug coverage from their decision to purchase coverage for less predictable health costs.

But most of the drug benefit proposals developed in recent years have sought to keep enrollment in the benefit as a separate option for the elderly and disabled. To mitigate the potential for adverse selection, they would use some or all of the following three methods:

- ***Restrict Participation.*** Most proposals have either given enrollees only one opportunity to choose the drug benefit—at the time they first become eligible for it—or imposed a substantial premium surcharge on those who delay enrollment. (Otherwise, beneficiaries with low drug costs would simply wait until they needed coverage to enroll.)
- ***Provide Up-Front Coverage.*** Many proposals have sought to make enrollment more attractive for beneficiaries with low drug costs by providing some coverage for their initial drug expenditures—for example, covering a substantial share of costs after beneficiaries meet a deductible that can be as low as $100.
- ***Offer High Premium Subsidy Rates.*** The extent of Federal subsidization of premiums for a drug benefit is a key determinant of total Federal costs for such a program both because of the direct costs and because the availability of subsidies would lead employers and State Medicaid programs to encourage or require full participation. However, such subsidies would also serve to encourage other beneficiaries with relatively low drug costs to enroll in the benefit. Most recent proposals have contained relatively high subsidy rates—67 percent or higher—which mean that enrollees would pay one-third or less of the average covered costs through their monthly premiums.

The Administration of a Medicare Drug Benefit

The way in which a drug benefit is administered also affects its costs, and the options for administration involve many of the same trade-offs between insurance and incentives that arise in designing the benefit itself. Most recent proposals have envisioned adopting the common private-sector approach of using pharmacy benefit managers (PBMs) to process drug claims. Those proposals would also give beneficiaries a range of drug plans from which to choose, either in conjunction with their choice of medical coverage or as a stand-alone benefit. The extent to which the organizations that administered a Medicare drug benefit could effectively constrain its costs would depend on the organizations' having both the authority and the incentive to use the various cost-control mechanisms at their disposal. Proposals have differed, however, in the nature and extent of the risk that the entities responsible for administering the benefit would assume, the kind of restrictions that would be placed on them in managing drug costs, and the structure of the competition among those entities to enroll and serve beneficiaries.

Private health plans use PBMs to process claims and negotiate price discounts with drug manufacturers and dispensing pharmacies. PBMs also try to encourage the use of certain drugs, such as generic, preferred-formulary, or mail-order pharmaceuticals—in part so that they can obtain lower prices for those preferred drugs that have competitors. In addition, because of their centralized records for each enrollee's prescriptions, they may help prevent adverse drug interactions and take other steps to help beneficiaries manage their own drug use.

In the private sector, PBMs often have considerable leeway in the tools they can use, but they do not assume any insurance risk for the drug benefit (although they may be guided or selected by an employer or insurer who does bear the residual risk). At most, they may be subject to a bonus or a penalty added to their administrative fee, which is based on how well they meet prespecified goals for their performance. Some proposals have envisioned having PBMs or similar entities administer a Medicare drug benefit in that way—accepting "performance risk" but not "insurance risk." In such models, all costs for benefit claims would be paid by the Federal Government as they were incurred.

Other proposals have adopted a different model, more akin to the risk-based competitive model characteristic of Medicare+Choice plans. Those proposals envision multiple risk-bearing entities (such as partnerships between PBMs and insurers) that would compete to serve enrollees. Enrollees would have some choice among providers, so that beneficiaries who were willing to accept more-restrictive rules (such as a closed formulary) in return for lower premium costs could do so, whereas others could select a more expensive provider with fewer restrictions. If the entities bore all of the insurance risk for the drug benefit—that is, if they received a fixed per capita payment for each enrollee—they would have strong incentives to use whatever cost-control tools were permitted. However, such tools might be unattractive to many beneficiaries, and the plans' administrators would also have strong incentives to try to achieve favorable selection by avoiding enrollees with the highest spending.

An additional concern about this model has been that entities might be unwilling to participate if they had to assume the full insurance risk for a stand-alone drug benefit. To mitigate that concern, proposals have included federally provided reinsurance for high-cost enrollees as well as so-called risk-adjustment mechanisms that would vary the per capita payments on the basis of enrollees' characteristics, such as their age or previous disease diagnoses. (Reinsurance means that the Federal Government shares part or all of the claims costs of high-cost enrollees.) Although reinsurance would reduce the incentives to avoid the highest-cost enrollees that risk-bearing plans face, it would also tend to weaken the plans' incentives to control costs commensurately.

Complicating matters further, the incentives to control drug costs faced by entities administering a Medicare drug benefit would not depend solely on how they were paid; the financial incentives that beneficiaries faced would also be a key consideration. Such incentives might include lower beneficiary premiums for joining plans that could deliver the required benefits for a lower overall cost, as well as smaller out-of-pocket payments in plans that were able to negotiate lower prices for the drugs they covered. If plans competed primarily on the basis of the comprehensiveness of the coverage they provided, however, Federal expenditures would probably be higher than if plans competed on cost factors. Moreover, to devise a proposal that would require plans to bear insurance risk but not allow beneficiaries' premiums to vary with their choice of plan appears to be difficult.

Although much depends on a proposal's specific design and details, a drug benefit could be structured so that entities bearing some insurance risk would choose to provide it; further, such coverage would probably be available across the country. That conclusion, which stands in contrast to the experience of the Medicare+Choice program, is based in part on the fact that the kind of competing pharmacy networks needed to provide such a drug benefit are already well established nationwide. At the same time, CBO concludes that plans bearing insurance risk would incur additional costs that would not be borne by PBMs that are subject only to performance risk. Whether and to what extent those added costs might offset any reductions in Federal costs that accrued from having plan administrators face insurance risk would also depend on the specific provisions of the proposal.

Finally, recent discussions have included the notion of linking drug coverage with reforms of the delivery mechanism for Medicare's benefits. For example, the Bush Administration has put forward a set of principles for Medicare reform that suggests an "integrated" approach combining drug benefits and enrollment in private health plans. The budgetary implications of such an approach are, however, unclear—the Administration estimated that its initiative would cost a total of $400 billion through 2013 but did not submit sufficient details for CBO to make its own estimate. CBO is preparing to estimate the effects of any such proposals and looks forward to working with the Congress if and when such initiatives are introduced as legislation.

Conclusion

In conclusion, I would be remiss if I did not emphasize the important trade-offs involved in all of the policies now under consideration. Even when considered in isolation, a Medicare drug benefit might address a number of objectives—but objectives

that might be thought desirable in the abstract are often mutually incompatible, necessitating difficult choices. For example, providing extensive drug coverage to all Medicare beneficiaries at a low cost to all parties is not possible; either enrollees' premiums or the government's subsidy costs would be high. If most of the costs were paid through enrollees' premiums to keep Federal spending low, some Medicare beneficiaries would be unwilling or unable to participate in the program, particularly if coverage was limited to catastrophic expenses. If, instead, costs were limited by capping the annual benefits paid to each enrollee, the program would fail to protect participants from the impact of catastrophic drug costs. Proposals have taken various approaches to balance those competing objectives.

Looking at the Medicare program as a whole, the choices may be even more stark. If the program continues to operate as it is currently structured, its costs will rise significantly—even in the absence of program expansions such as a prescription drug benefit. In light of that outlook, policymakers may wish to incorporate two features in their approach to Medicare policy: a recognition of the larger economic and budgetary trade-offs, and consideration of the program structure that would best support Medicare's overall objective of providing financing for high-quality medical care for the elderly and disabled.

With regard to economic and budgetary trade-offs, two issues stand out. First, to the extent that the U.S. economy grows at a healthy pace, it will be better able to meet the Medicare population's demands for health care. Put differently, the overall level of national income available in the future constitutes the reservoir from which the resources for both private needs and public programs will be drawn, and the nation must endeavor, in making public policy, to enlarge that reservoir to the greatest degree possible. Second, the potential pressures on the Federal budget from Medicare and other sources will necessitate trade-offs with other spending priorities if Federal programs are to remain close to their historical fraction of national income.

Alternatively, public policy may steer a course toward devoting a larger fraction of the Federal budget and the economy as a whole to Medicare. Even if that occurs, it will be desirable to use those Medicare funds as efficiently as possible—to purchase the highest-value care with each dollar. Medicare beneficiaries (or their families), together with their health care providers, are best positioned to guide the use of additional dollars and to choose services that meet therapeutic demands and match individual tastes. Providing those parties with a broader range of choices and improved information, and ensuring their sensitivity to the cost of those services, should facilitate better decisionmaking. At the same time, an appropriate balance must be struck between providing stronger financial signals to beneficiaries about the cost of their care and providing protection against greater financial exposure—in the program as a whole and in any drug benefit that is added to it.

This concludes my testimony, and I look forward to answering any questions that the Committee may have.

Chairman THOMAS. Thank you very much, Doctor. Mr. Walker?

STATEMENT OF THE HONORABLE DAVID M. WALKER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE

Mr. WALKER. Thank you, Mr. Chairman, Ranking Member Rangel. It is a pleasure to be back before the full Committee on Ways and Means to discuss Medicare's financial condition and proposals to add an outpatient prescription drug benefit. I will hit the highlights, if I can, Mr. Chairman.

There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which can leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. At the same time, however, the recent publication of the 2003 trustees Annual Report reminds us that Medicare, based on its current design, with no prescription drug benefit, already faces a huge projected financial imbalance and that has worsened significantly in the past year.

Furthermore, as the Medicare trustees made clear over 10 years ago, the current Medicare program is not fiscally sustainable in its present form. In fact, that was done in the year that I was a trustee of Social Security and Medicare. In 10 years, Hospital Insurance (HI) Trust Fund outlays will begin to exceed tax revenues, and by 2026, the HI Trust Fund will be exhausted. However, trust fund insolvency does not mean that the program will cease to exist. Program tax revenues will cover a portion of projected annual expenditures thereafter.

In the face of these short-term and long-term cost pressures, I continue to maintain that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The trustees' intermediate projections in the 2003 report show that program outlays are expected to begin to exceed program tax revenues in 2013. That is when we go negative cash flow. Cash is key, not trust fund solvency. In fact, trust fund solvency can be misleading and give people a false sense of security as to not only the state of this program, but also Social Security.

To finance these cash deficits, HI will have to draw on special issue Treasury securities acquired during the years of surpluses. To redeem those securities, the government will have to obtain cash through a combination of increased taxes, spending cuts, and/or increased borrowing from the public, through publicly held debt. Neither the decline in the cash surpluses nor the cash deficits will affect the payment of benefits for a member of years. The negative cash flow will place increased pressure on the Federal budget to raise resources necessary to meet the program's ongoing costs. This pressure will only increase when Social Security begins to experience a negative cash flow just a few short years after the Medicare program.

Importantly, the HI Trust Fund measure provides no information on Supplemental Medical Insurance (SMI), or Part B, SMI. The SMI's expenditures, which currently account for about 43 percent of total Medicare spending, are projected to grow even faster than HI.

Ultimately, the critical question is not how much the trust fund has in assets, but whether the government as a whole and the economy at large can afford the promised benefits now and in the future, and at what cost to other claims on available resources. As shown in the next chart, Medicare, Medicaid, and Social Security have already grown from 13 percent of Federal spending in 1962—again, before Medicare and Medicaid were enacted into law—to 42 percent of Federal spending in 2002. These percentages are expected to continue to increase in future years.

As the next chart shows, GAO prepares long-term budget simulations twice a year, based upon CBO data and then going out much further, that seek to illustrate the likely fiscal consequences of the coming demographic tidal wave and rising health care cost. These simulations continue to show that to move into the future with no changes in Federal retirement and health programs is to envision a very different role for the Federal Government. In addition, while additional economic growth would help to ease our burden, the projected fiscal gap is too great for us to grow our way out of the problem.

At the same time, it is important to look beyond the Federal budget to the economy as a whole. If we look at the next chart, we will see that Medicare, Medicaid, and Social Security are projected to represent an ever-increasing percentage of the overall economy. Under the 2003 trustees' intermediate estimates and the CBO's most recent long-term Medicare estimates, spending for these entitlement programs combined will grow to 14 percent of GDP in 2030 from today's 8.4 percent.

Despite a common awareness of Medicare's current and future fiscal plight, pressure has been building to address recognized gaps in Medicare's coverage, especially the lack of a prescription drug benefit and protection against financially devastating medical costs. Filling these gaps would add expenses to an already fiscally overburdened program. Under the trustees' 2003 intermediate assumptions, the present value of HI's Part A's actuarial deficit in current dollars is $6.2 trillion. We would have to have $6.2 trillion today invested at Treasury rates in order to fund the gap for Part A alone, a 20-percent increase from last year.

As a result, it would be prudent for the Congress to consider tackling the greatest needs first and for making any benefit additions part of a larger structural reform effort. In addition, Congress may want to adopt a Medicare Hippocratic oath, namely, do not make Medicare's already huge financial imbalance worse.

In closing, Medicare's financial challenge is very real and growing. The 21st century has arrived, and our demographic tidal wave is on the horizon. Frankly, we know that incorporating a prescription drug benefit in the existing Medicare program will add hundreds of billions of dollars to the program spending just over 10 years.

Finally, in my view, Congress should consider the estimated discounted present value of any major tax or spending actions like this as an integral part of any related discussion and debate and prior to enactment of any related legislation. This information is critical in light of our long-range fiscal challenge and the Congress' overall stewardship obligations to the American people.

Thank you, Mr. Chairman. I am happy to answer any questions you may have.

[The prepared statement of Mr. Walker follows:]

Statement of The Honorable David M. Walker, Comptroller General, U.S. General Accounting Office

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss issues related to an outpatient prescription drug benefit for Medicare beneficiaries. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. Recent estimates suggest that, at any point in time, about a third of Medicare beneficiaries lack prescription drug coverage. The rest have at least some drug coverage through various sources—most commonly employer-sponsored health plans—although recent evidence indicates that this coverage is beginning to erode.

At the same time, however, the recent publication of the 2003 Trustees' Annual Report reminds us that Medicare in its current condition—with no prescription drug benefit—already faces a huge projected financial imbalance that has worsened significantly in the past year. Furthermore, as the Medicare trustees made clear over 10 years ago, the current Medicare program is not fiscally sustainable in its present form.

In 10 years, Hospital Insurance (HI) Trust Fund outlays will begin to exceed tax receipts, and by 2026 the HI Trust Fund will be exhausted. However, trust fund insolvency does not mean the program will cease to exist; program tax revenues will continue to cover a portion of projected annual expenditures.[1]

The huge fiscal pressures created by the retirement of the baby boom generation and rising health care costs are on our 10-year budget horizon. Between now and 2035, the number of people age 65 and older will double. Federal health and retirement spending are expected to surge as people live longer and spend more time in retirement. In addition, advances in medical technology are likely to keep pushing up the cost of providing health care. Moreover, the baby boomers will have fewer workers to support them in retirement.

We must also remember that Medicare has grown substantially as a percent of the Federal budget since its enactment in 1965. In addition, it is expected to represent an increasing percentage of the Federal budget in the years ahead. After a brief slowdown in the late 1990s, Medicare spending growth has recently accelerated. In fiscal year 2001, growth in program spending reached nearly 9 percent, with spending on certain services increasing much more rapidly. For example, spending for home health services grew about 30 percent and spending for skilled nursing facility care grew slightly over 20 percent. For the first 5 months of fiscal year 2003, Medicare spending has been growing at 7.6 percent.[2]

A significant problem that hobbles Medicare's ability to achieve a desirable degree of efficiency is that the program too often pays overly generous rates for certain services and products. For example, for certain services, our recent work has shown substantially higher Medicare payments relative to providers' costs—as much as 35 percent higher for home health care and 19 percent higher for skilled nursing facility care.[3] Similarly, Medicare has overpaid for various medical products. In 2001, we reported that Medicare paid over $1 billion more than other purchasers in 2000 for certain outpatient drugs that the program covers. Excessive payments hurt not only the taxpayers but also the program's beneficiaries or their supplemental insurers, as beneficiaries are generally liable for copayments equal to 20 percent of Medicare's approved fee. For certain outpatient drugs, Medicare's payments to providers were so high that the beneficiaries' copayments exceeded the price at which providers could buy the drugs. The Centers for Medicare & Medicaid Services (CMS) has not acted on our recommendation that Medicare establish payment levels for drugs more closely related to actual market transaction costs, using information available to other public programs that pay at lower rates.[4]

In the face of these short-term and long-term cost pressures, I continue to maintain that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. These fundamental reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, any proposals to help seniors with the costs of prescription drugs would need to be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program. Stated differently, it will be prudent to adopt a modified Hippocratic oath for Medicare reform—namely, any such reform proposals should "do no further harm" to Medicare's already serious long-range financial imbalance.

As you deliberate on ways to modernize Medicare's benefit package while striving for program sustainability, I would like to highlight several key considerations:

- The traditional measure of HI Trust Fund solvency is a misleading gauge of Medicare's financial health. Long before the HI Trust Fund is projected to be insolvent, pressures on the rest of the Federal budget will grow as HI's projected cash flow turns negative and the gap between program tax revenues and expenditures escalates. Moreover, a focus on the financial status of HI ignores the increasing burden Supplemental Medical Insurance (SMI)—Medicare Part B—will place on taxpayers and beneficiaries.

---

[1] Under the Trustees 2003 intermediate assumptions, revenues from the HI payroll tax and the taxation of certain Social Security benefits are initially projected to cover about three-fourths of projected expenditures once the trust fund is exhausted. This ratio, however, is projected to decline rapidly.

[2] Congressional Budget Office, *Monthly Budget Review* (Washington, D.C.: Mar. 10, 2003).

[3] See U.S. General Accounting Office, Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs, GAO–02–663 (Washington, D.C.: May 6, 2002) and Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities, GAO–03–183 (Washington, D.C.: Dec. 31, 2002).

[4] U.S. General Accounting Office, Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Costs, GAO–01–1118 (Washington, D.C.: Sept. 21, 2001).

- GAO's most recent long-term budget simulations continue to show that, absent meaningful entitlement reforms, demographic trends and rising health care spending will drive escalating Federal deficits and debt. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. Neither slowing the growth of discretionary spending nor allowing the 2001 tax reductions to sunset will eliminate the imbalance. In addition, while additional economic growth will help ease our burden, the potential fiscal gap is too great to grow our way out of the problem.
- Under the huge budgetary pressures that we are sure to face in the coming years, we must set priorities so that any benefit expansions are in line with available resources. In this regard, the application of basic health insurance principles to any proposed benefit could help moderate the cost for both beneficiaries and taxpayers. Under these principles, beneficiaries receive protections against the risk of catastrophic medical expenses while remaining conscious of the cost of care through their premium contributions and cost-sharing arrangements. Given our already huge Medicare financial imbalance, it is also important that benefit expansion proposals include targeting mechanisms to ensure that Federal support is directed at the beneficiaries with the greatest financial risk.
- The private sector's use of entities called pharmacy benefit managers for controlling drug expenditures may be instructive for Medicare, but the program's unique role and nature may moderate how these strategies will be used and the potential efficiency gains afforded in attempting to transfer these strategies to Medicare.

Outlook Worsening for Medicare's Long-Term Sustainability

Today the Medicare program faces a long-range and fundamental financing problem driven by known demographic trends and projected escalation of health care spending beyond general inflation. The lack of an immediate crisis in Medicare financing affects the nature of the challenge, but it does not eliminate the need for change. Within the next 10 years, the first baby boomers will begin to retire, putting increasing pressure on the Federal budget. From the perspectives of the program, the Federal budget, and the economy, Medicare in its present form is not sustainable. Acting sooner rather than later would allow changes to be phased in so that the individuals who are most likely to be affected, namely younger and future workers, will have time to adjust their retirement planning while helping to avoid related "expectation gaps." Since there is considerable confusion about Medicare's current financing arrangements, I would like to begin by describing the nature, timing, and extent of the financing problem.

Demographic Trends and Expected Rise in Health Care Costs Drive Medicare's Long-Term Financing Problem

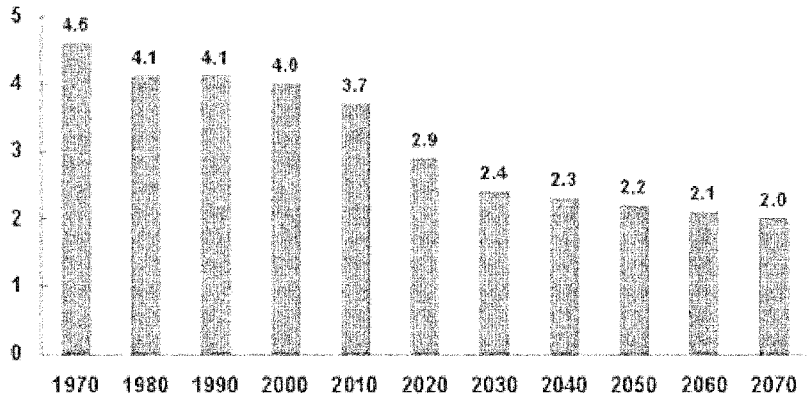
As you know, Medicare consists of two parts—HI and SMI. HI, which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services, is financed by a payroll tax. Like Social Security, HI has always been largely a pay-as-you-go system. SMI, which pays for physician and outpatient hospital services, diagnostic tests, and certain other medical services, is financed by a combination of general revenues and beneficiary premiums. Beneficiary premiums pay for about one-fourth of SMI benefits, with the remainder financed by general revenues. These complex financing arrangements mean that current workers' taxes primarily pay for current retirees' benefits except for those financed by SMI premiums.[5]

As a result, the relative numbers of workers and beneficiaries have a major impact on Medicare's financing. The ratio, however, is changing. In the future, relatively fewer workers will be available to shoulder Medicare's financial burden. In 2002 there were 4.9 working-age persons (18 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.8. For the HI portion of Medicare, in 2002 there were nearly 4 covered workers per HI beneficiary. Under their intermediate 2003 estimates, the Medicare trustees project that by 2030 there will be only 2.4 covered workers per HI beneficiary. (See fig. 1.)

---

[5] Another small source of funding derives from the tax treatment of Social Security benefits. Under certain circumstances, up to 85 percent of an individual's or couple's Social Security benefits are subject to income taxes. Under present law, the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds are credited with the income taxes attributable to the taxation of the first 50 percent of OASDI benefit payments. The remainder of the income taxes attributable to the taxation of up to 85 percent of OASDI benefit payments is credited to the HI Trust Fund. Any other income taxes paid by retirees would also help finance the general revenue contribution to SMI.

Figure 1.—Ratio of HI-Covered Workers to Beneficiaries

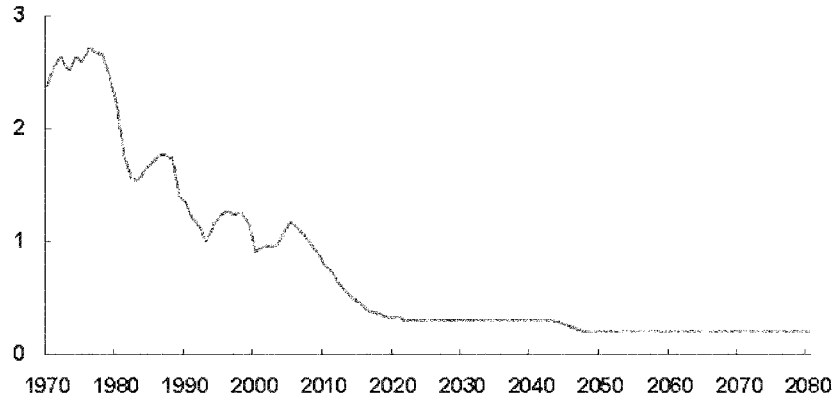


Source: CMS, Office of the Actuary.
Note: Projections based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The demographic challenge facing the system has several causes. People are retiring early and living longer. As the baby boom generation ages, the share of the population age 65 and over will escalate rapidly. A falling fertility rate is the other principal factor underlying the growth in the elderly's share of the population. In the 1960s, the fertility rate was an average of 3 children per woman. Today it is a little over 2, and by 2030 it is expected to fall to 1.95—a rate that is below replacement. The combination of the aging of the baby boom generation, increased longevity, and a lower fertility rate will drive the elderly as a share of total population from today's 12 percent to almost 20 percent in 2030.

Taken together, these trends threaten both the financial solvency and fiscal sustainability of this important program. Labor force growth will continue to decline and by 2025 is expected to be less than a third of what it is today. (See fig. 2.) Relatively fewer workers will be available to produce the goods and services that all will consume. Without a major increase in productivity, low labor force growth will lead to slower growth in the economy and slower growth of Federal revenues. This in turn will only accentuate the overall pressure on the Federal budget. This slowing labor force growth is not always recognized as part of the Medicare debate, but it is expected to affect the ability of the Federal budget and the economy to sustain Medicare's projected spending in the coming years.

Figure 2.—Labor Force Growth



Source: Social Security Administration, Office of the Chief Actuary, and GAO.
Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds*. Percentage change is calculated as a centered 5-year moving average.

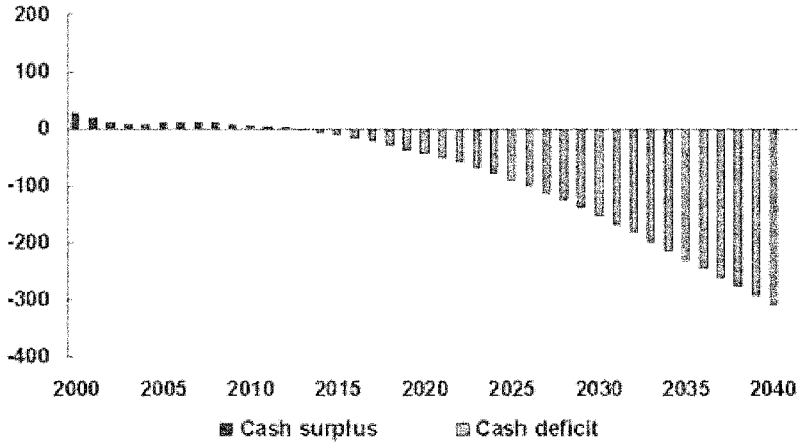
The demographic trends I have described will affect both Medicare and Social Security, but Medicare presents a much greater, more complex, and more urgent challenge. Unlike Social Security, Medicare spending growth rates reflect not only a burgeoning beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. The growth of medical technology has contributed to increases in the number and quality of health care services. Moreover, the actual costs of health care consumption are not transparent. Third-party payers largely insulate covered consumers from the cost of health care decisions. These factors and others contribute to making Medicare a greater and more complex fiscal challenge than Social Security.

HI's Trust Fund Faces Cash Flow Problems Long Before the HI Trust Fund Is Projected to Be Insolvent

Current projections of future HI income and outlays illustrate the timing and severity of Medicare's fiscal challenge. Today, the HI Trust Fund takes in more in taxes than it spends. Largely because of the known demographic trends I have described, this situation will change. Under the trustees' 2003 intermediate assumptions, program outlays are expected to begin to exceed program tax revenues in 2013. (See fig. 3.) To finance these cash deficits, HI will need to draw on the special-issue Treasury securities acquired during the years of cash surpluses. For HI to "redeem" its securities, the government will need to obtain cash through some combination of increased taxes, spending cuts, and/or increased borrowing from the public (or, if the unified budget is in surplus, less debt reduction than would otherwise have been the case). Neither the decline in the cash surpluses nor the cash deficits will affect the payment of benefits, but the negative cash flow will place increased pressure on the Federal budget to raise the resources necessary to meet the program's ongoing costs. This pressure will only increase when Social Security also experiences negative cash flow and joins HI as a net claimant on the rest of the budget.[6]

[6] Under the trustees' intermediate 2003 projections, this will occur for Social Security (OASDI) in 2018.

Figure 3.—Medicare's HI Trust Fund Faces Cash Deficits as Baby Boomers Retire



Source: CMS, Office of the Actuary and GAO.
Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The gap between HI income and costs shows the severity of HI's financing problem over the longer term. This gap can also be expressed relative to taxable payroll (the HI Trust Fund's funding base) over a 75-year period. This year, under the trustees' 2003 intermediate estimates, the 75-year actuarial deficit is projected to be 2.40 percent of taxable payroll—a significant increase from last year's projected deficit of 2.02 percent. This means that to bring the HI Trust Fund into balance over the 75-year period, either program outlays would have to be immediately reduced by 42 percent or program income immediately increased by 71 percent, or some combination of the two. These estimates of what it would take to achieve 75-year trust fund solvency understate the extent of the problem because the program's financial imbalance gets worse in the 76th and subsequent years. As each year passes, we drop a positive year and add a much bigger deficit year.

The projected exhaustion date of the HI Trust Fund is a commonly used indicator of HI's financial condition. Under the trustees' 2003 intermediate estimates, the HI Trust Fund is projected to exhaust its assets in 2026. This solvency indicator provides information about HI's financial condition, but it is not an adequate measure of Medicare's sustainability for several reasons. In fact, the solvency measure can be misleading and can serve to give a false sense of security as to Medicare's true financial condition. Specifically, HI Trust Fund balances do not provide meaningful information on the government's fiscal capacity to pay benefits when program cash inflows fall below program outlays. As I have described, the government would need to come up with cash from other sources to pay for benefits once outlays exceeded program tax income.

In addition, the HI Trust Fund measure provides no information on SMI. SMI's expenditures, which currently account for about 43 percent of total Medicare spending, are projected to grow even faster than those of HI in the near future. Moreover, Medicare's complex structure and financing arrangements mean that a shift of expenditures from HI to SMI can extend the solvency of the HI Trust Fund, creating the appearance of an improvement in the program's financial condition. For example, the Balanced Budget Act of 1997 modified the home health benefit, which resulted in shifting a portion of home health spending from the HI Trust Fund to SMI. Although this shift extended HI Trust Fund solvency, it increased the draw on general revenues and beneficiary SMI premiums while generating little net savings.

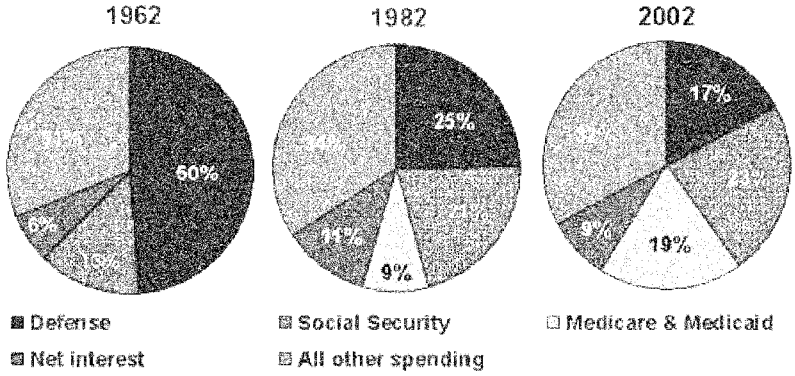
Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole and the economy can afford the promised benefits now and in the future and at what cost to other claims on available resources. To better monitor and communicate changes in future total program spending, new measures of Medicare's sustainability are needed. As program changes are made, a

continued need will exist for measures of program sustainability that can signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total Federal revenues or gross domestic product (GDP) devoted to Medicare, or program spending per enrollee. As such measures are developed, questions would need to be asked about actions to be taken if projections showed that program expenditures would exceed the chosen level.

Absent Reform of Medicare and Other Entitlements for the Elderly, Budgetary Flexibility Will Disappear

Taken together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent of Federal revenues in 2002 to more than one-quarter by midcentury. The budgetary challenge posed by the growth in Medicare becomes even more significant in combination with the expected growth in Medicaid and Social Security spending. As shown in figure 4, Medicare, Medicaid, and Social Security have already grown from 13 percent of Federal spending in 1962 before Medicare and Medicaid were created to 42 percent in 2002.

Figure 4.—Composition of Federal Spending by Budget Function, 1962, 1982, and 2002

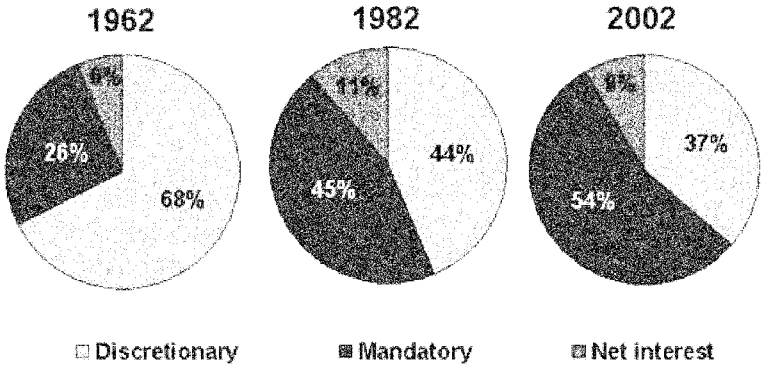


Source: CMS, Office of the Actuary and GAO.

This growth in spending on Federal entitlements for retirees will become increasingly unsustainable over the longer term, compounding an ongoing decline in budgetary flexibility. Over the past few decades, spending on mandatory programs has consumed an ever-increasing share of the Federal budget.[7] In 1962, prior to the creation of the Medicare and Medicaid programs, spending for mandatory programs plus net interest accounted for about 32 percent of total Federal spending. By 2002, this share had almost doubled to approximately 63 percent of the budget. (See fig. 5.)

[7] "Mandatory spending" refers to outlays for entitlement programs such as food stamps, Medicare, and veterans' pensions; payment of interest on the public debt; and outlays for certain nonentitlement programs such as payments to States from Forest Service receipts. In 2002 Social Security, Medicare, and Medicaid accounted for over 71 percent of mandatory spending.

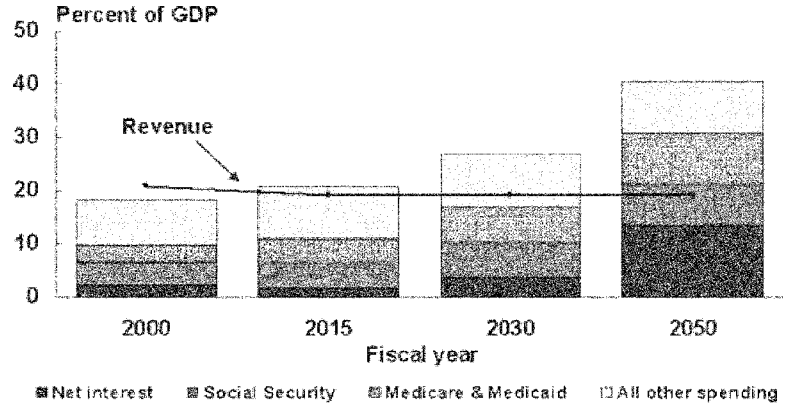
Figure 5.—Federal Spending for Mandatory and Discretionary Programs, Fiscal Years 1962, 1982, and 2002



In much of the past decade, reductions in defense spending helped accommodate the growth in these entitlement programs. However, even before the terrorist attacks of September 11, 2001, this ceased to be a viable option. Indeed, spending on defense and homeland security will grow as we seek to combat new threats to our nation's security.

GAO prepares long-term budget simulations that seek to illustrate the likely fiscal consequences of the coming demographic tidal wave and rising health care costs. These simulations continue to show that to move into the future with no changes in Federal retirement and health programs is to envision a very different role for the Federal Government. Assuming, for example, that the tax reductions enacted in 2001 do not sunset and discretionary spending keeps pace with the economy, by midcentury Federal revenues may not even be adequate to pay Social Security and interest on the Federal debt. Spending for the current Medicare program—without any additional new benefits—is projected to account for more than one-quarter of all Federal revenues. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. (See fig. 6.) Neither slowing the growth of discretionary spending nor allowing the tax reductions to sunset eliminates the imbalance. In addition, while additional economic growth would help ease our burden, the projected fiscal gap is too great for us to grow our way out of the problem.

Figure 6.—Composition of Spending as a Share of GDP Assuming Discretionary Spending Grows With GDP After 2003 and the 2001 Tax Cuts Do Not Sunset



Source: GAO's March 2003 analysis.

Note: Assumes currently scheduled Social Security benefits are paid in full throughout the simulation period. Social Security and Medicare projections are based on the trustees' 2003 intermediate assumptions.

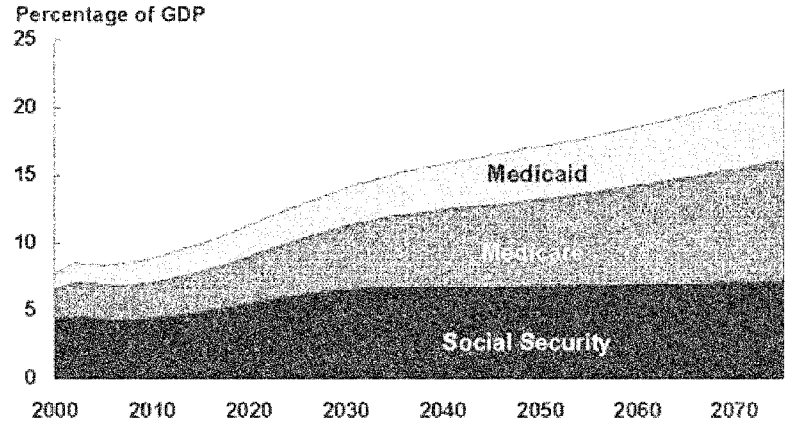
Indeed, long-term budgetary flexibility is about more than Social Security and Medicare. While these programs dominate the long-term outlook, they are not the only Federal programs or activities that bind the future. The Federal Government undertakes a wide range of programs, responsibilities, and activities that obligate it to future spending or create an expectation for spending. A recent GAO report describes the range and measurement of such fiscal exposures—from explicit liabilities such as environmental cleanup requirements to the more implicit obligations presented by life-cycle costs of capital acquisition or disaster assistance.[8] Making government fit the challenges of the future will require not only dealing with the drivers—such as entitlements for the elderly—but also looking at the range of other Federal activities. A fundamental review of what the Federal Government does and how it does it will be needed. This involves looking at the base of all major spending and tax policies to assess their appropriateness, priority, affordability, and sustainability in the years ahead.

Medicare Is Projected to Absorb Ever-Increasing Shares of the Economy

At the same time, it is important to look beyond the Federal budget to the economy as a whole. Figure 7 shows the total future draw on the economy represented by Medicare, Medicaid, and Social Security. Under the 2003 trustees' intermediate estimates and the Congressional Budget Office's (CBO) most recent long-term Medicaid estimates, spending for these entitlement programs combined will grow to 14 percent of GDP in 2030 from today's 8.4 percent. Taken together, Social Security, Medicare, and Medicaid represent an unsustainable burden on future generations.

[8] U.S. General Accounting Office, Fiscal Exposures: Improving the Budgetary Focus on Long-Term Costs and Uncertainties, GAO–03–213 (Washington, D.C.: Jan. 24, 2003).

Figure 7: Social Security, Medicare, and Medicaid Spending as a Percentage of GDP



Source: CMS, Office of the Actuary, SSA, Office of the Chief Actuary, CBO, and GAO.
Note: Projections based on the intermediate assumptions of the 2003 trustees' Reports, CBO's March 2003 short-term Medicaid estimates, and CBO's June 2002 Medicaid long-term projections under midrange assumptions.

Although real incomes are projected to continue to rise, they are expected to grow more slowly than has historically been the case. At the same time, the demographic trends and projected rates of growth in health care spending I have described will mean rapid growth in entitlement spending. Taken together, these projections raise serious questions about the capacity of the relatively smaller number of future workers to absorb the rapidly escalating costs of these programs.

As HI Trust Fund assets are redeemed to pay Medicare benefits and SMI expenditures continue to grow, the program will constitute a claim on real resources in the future. As a result, taking action now to increase the future pool of resources is important. To echo Federal Reserve Chairman Alan Greenspan, the crucial issue of saving in our economy relates to our ability to build an adequate capital stock to produce enough goods and services in the future to accommodate both retirees and workers in the future.[9] The most direct way the Federal Government can raise national saving is by increasing government saving; that is, as the economy returns to a higher growth path, a balanced fiscal policy that recognizes our long-term challenges can help provide a strong foundation for economic growth and can enhance our future budgetary flexibility. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Putting Medicare on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the Federal Government to play.

As with Social Security, both sustainability and solvency considerations drive us to address Medicare's fiscal challenges sooner rather than later. HI Trust Fund exhaustion may be more than 20 years away, but the squeeze on the Federal budget will begin as the baby boom generation begins to retire. This will begin as early as 2008, when the leading edge of the baby boom generation becomes eligible for early retirement.[10] CBO's current 10-year budget and economic outlook reflects this. CBO projects that economic growth will slow from an average of 3.2 percent a year from 2005 through 2008 to 2.7 percent from 2009 through 2013, reflecting slower labor force growth. At the same time, annual rates of growth in entitlement spending will begin to rise. Annual growth in Social Security outlays is projected to accelerate

[9] Testimony before the Senate Committee on Banking, Housing, and Urban Affairs, July 24, 2001.

[10] In 2008, the first baby boomers will reach age 62 and become eligible for Social Security benefits; in 2011, they will reach age 65 and become eligible for Medicare benefits.

from 5.2 percent in 2007 to 6.6 percent in 2013. Annual growth in Medicare enrollees is expected to accelerate from 1.1 percent today to 2.9 percent in 2013. Acting sooner rather than later is essential to ease future fiscal pressures and also provide a more reasonable planning horizon for future retirees. We are now at a critical juncture. In less than a decade, the profound demographic shift that is a certainty will have begun.

As Bleak Fiscal Future Looms, Efforts to Address Medicare Coverage Gaps Are Being Considered

Despite a common awareness of Medicare's current and future fiscal plight, pressure has been building to address recognized gaps in Medicare coverage, especially the lack of a prescription drug benefit and protection against financially devastating medical costs. Filling these gaps could add significant expenses to an already fiscally overburdened program. Under the trustees' 2003 intermediate assumptions, the present value of HI's actuarial deficit is $6.2 trillion, a 20-percent increase from the prior year.[11] This difficult situation argues for tackling the greatest needs first and for making any benefit additions part of a larger structural reform effort.

The Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage. Beneficiaries may fill this coverage gap in various ways. According to the Medicare Current Beneficiary Survey, nearly two-thirds of Medicare beneficiaries had some form of drug coverage from a supplemental insurance policy, health plan, or public program at some point during 1999. All beneficiaries have the option to purchase supplemental policies—Medigap—when they first become eligible for Medicare at age 65. Those policies that include drug coverage tend to be expensive and provide only limited benefits. Some beneficiaries have access to coverage through employer-sponsored policies or private health plans that contract to serve Medicare beneficiaries. In recent years, coverage through these sources has become more expensive and less widely available. Beneficiaries whose incomes fall below certain thresholds may qualify for Medicaid or other public programs. More than one-third may lack drug coverage altogether.

In recent years, prescription drug expenditures have grown substantially, both in total and as a share of all heath care outlays. Prescription drug spending grew an average of 15.9 percent per year from 1996 to 2001, more than double the 6.5 percent average growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a growing share of health care spending, rising from 6.5 percent in 1996 to 9.9 percent in 2001. By 2012, prescription drug expenditures are expected to account for almost 15 percent of total health expenditures.

Table 1.—National Expenditures for Prescription Drugs and Health Care, 1996 to 2001

Year	Prescription Drug Expenditures (in billions)	Annual Growth In Prescription Drug Expenditures From Previous Year (percent)	Annual Growth In Health Care Expenditures From Previous Year (percent)
2001	$140.6	15.4	8.7
2000	121.8	17.3	6.9
1999	103.9	19.2	5.7
1998	87.2	15.1	5.4
1997	75.7	12.8	4.9
1996	67.2	10.5	5.0
Average annual growth from 1996 through 2001		15.9	6.5

Source: CMS, Office of the Actuary.

In 2002, CBO projected that the average Medicare beneficiary would use $2,440 worth of prescription drugs in 2003. This is a substantial amount considering that

[11] This estimate represents the present value of HI's future expenditures less future tax income, taking into account the amount of HI Trust Fund assets at hand at the beginning of the projection period and adjusting for the ending target trust fund balance. Excluding the ending target trust fund balance, HI's unfunded obligation is estimated to be $5.9 trillion over the 75-year period under the trustees' 2003 intermediate assumptions.

some beneficiaries lack any drug coverage and others may have less coverage than in previous years. Moreover, significant numbers of beneficiaries have drug expenses much higher than those of the average beneficiary. CBO also estimated that, in 2005, 12 percent of Medicare beneficiaries would have expenditures above $6,000.

In focusing on the need for prescription drug coverage, we should not forget that Medicare does not provide complete protection from catastrophic losses. Under Medicare, beneficiaries have no limit on their out-of-pocket costs attributable to cost sharing. The average beneficiary who obtained services had a total liability for Medicare-covered services of $1,700, consisting of $1,154 in Medicare copayments and deductibles in addition to the $546 in annual Part B premiums in 1999, the most recent year for which data are available on the distribution of these costs. For beneficiaries with extensive health care needs, the burden can be much higher. In 1999, about 1 million beneficiaries were liable for more than $5,000, and about 260,000 were liable for more than $10,000 for covered services. In contrast, employer-sponsored health plans for active workers typically limited maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[12]

Recently, several proposals have been made to add a prescription drug benefit to the Medicare program. While different in scope and detail, the proposals have certain features in common—including use of a third-party entity to administer the new drug benefit. The remainder of my remarks will focus on the lessons learned from our work regarding the private sector's use of such an entity to manage the drug benefits of insurers' policyholders and health plans' enrollees.

Private Sector Strategies for Controlling Drug Expenditures May Be Instructive for Medicare

Some proposals to add a Medicare outpatient prescription drug benefit look to private sector strategies as a means to administer a drug benefit and control costs. Most employer-sponsored health plans contract with private entities, known as pharmacy benefit managers (PBM), to administer their prescription drug benefits, and those that do not contract with PBMs may have units in their organizations that serve the same administrative purpose. Typically, on behalf of the health plans, PBMs negotiate drug prices with pharmacies, negotiate rebates with drug manufacturers, process drug claims, operate mail-order pharmacies, and employ various cost-control techniques, such as formulary management and drug utilization reviews. In 2001, nearly 200 million Americans had their prescription drug benefits administered through PBMs. This year, we reported on the use of PBMs by health plans in the Federal Employees' Health Benefits Program (FEHBP).[13] In considering the application of these findings to Medicare, we are reminded that Medicare's unique role and nature may temper how the strategies and potential efficiency gains afforded by private sector PBMs may be transferred to benefit the program.

Private Sector Uses PBMs to Leverage Price Negotiations through Volume Purchasing

PBMs use purchasing volume to leverage their negotiations with pharmacies and drug manufacturers in seeking favorable prices in the form of discounts, rebates, or other advantages. Through negotiations, PBMs create networks of participating retail pharmacies, promising the pharmacies a greater volume of customers in exchange for discounted prices. PBMs may be able to secure larger discounts by limiting the number of network pharmacies. However, smaller networks provide beneficiaries fewer choices of retailers, thereby limiting convenient access. These are trade-offs health plans must consider in deciding how extensive a pharmacy network they want their PBMs to offer beneficiaries. The health plans we reviewed in our FEHBP study generally provided broad retail pharmacy networks. The average discounted prices PBMs obtained for drugs from retail pharmacies were about 18 percent below the average prices cash-paying customers without drug coverage would have paid for 14 selected widely used brand-name drugs. For 4 selected ge-

---

[12] The Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits: 2000 Annual Survey (Menlo Park, Calif. and Chicago: 2000).

[13] U.S. General Accounting Office, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies, GAO–03–196 (Washington, D.C.: Jan. 10, 2003). FEHBP covered about 8.3 million Federal employees, retirees, and their dependents as of July 2002, and the three FEHBP plans we reviewed accounted for about 55 percent of FEHBP enrollment. The FEHBP plans and PBMs we reviewed were Blue Cross and Blue Shield, which contracted with AdvancePCS for retail pharmacy services and Medco Health Solutions for mail-order services; Government Employees Hospital Association, which contracted with Medco Health Solutions; and PacifiCare of California, which contracted with Prescription Solutions, another subsidiary of PacifiCare Health Systems.

neric drugs, the PBM-negotiated retail pharmacy prices were 47 percent below the price paid by cash-paying customers.

PBMs also use their leverage to negotiate with drug manufacturers for rebates. Rebates generally depend on the volume of a manufacturer's products purchased. Health plans and PBMs can add to that volume by concentrating beneficiaries' purchases for particular types of drugs with certain manufacturers. Health plans can steer their beneficiaries' purchases to specific drugs through the use of a formulary—that is, a list of prescription drugs that health plans encourage physicians to prescribe and beneficiaries to use. Determining whether a drug should be on the formulary involves clinical evaluations based on a drug's safety and effectiveness, and decisions on whether several drugs are therapeutically equivalent.[14] Restricting the formulary to fewer drugs within a therapeutic class can provide the PBMs with greater leverage in negotiating higher rebates because they can help increase the manufacturer's market share for certain drugs. However, a restricted formulary provides beneficiaries with fewer preferred drug alternatives and makes the policies governing coverage of nonformulary drugs or the cost sharing for them critical to beneficiaries.[15]

The FEHBP plans and PBMs we reviewed provided enrollees with generally nonrestrictive drug formularies across a broad range of drugs and therapeutic categories.[16] The manufacturer rebates that the PBMs passed through to the FEHBP plans effectively reduced plans' annual spending on prescription drugs by a range of 3 percent to 9 percent. The share of rebates PBMs passed through to the FEHBP plans varied subject to contractual agreements negotiated between the plans and the PBMs.

PBMs also assisted the FEHBP plans by providing a less expensive mail-order drug option. Mail-order prices for the FEHBP plans we reviewed averaged about 27 percent lower than cash-paying customers would pay for the same quantity at retail pharmacies for 14 brand-name drugs and 53 percent lower for 4 generic drugs. The FEHBP plans generally had lower cost-sharing requirements for drugs purchased through mail order, particularly for more expensive brand-name drugs or maintenance medications for chronic conditions.

The claims and information processing capabilities PBMs offered also helped the FEHBP plans to manage drug costs and monitor quality of care. PBMs maintain a centralized database on each enrollee's drug history that can be used to review for potential adverse drug interactions or potentially less expensive alternative medications. They also use claims data to monitor patterns of patient use, physician prescribing practices, and pharmacy dispensing practices. Their systems provide "real-time" claims adjudication capabilities that allow a customer's claim for a drug purchase to be approved or denied at the time the pharmacist begins the process of filling a prescription. Two plans in our FEHBP study reported savings ranging from 6 to 9 percent of the plan's annual drug spending; the savings were associated primarily with real-time claims denials preventing early drug refills and safety advisories cautioning pharmacists about potential adverse interactions or therapy duplications.

Use of Private-Sector Strategies in Medicare Would Represent Departure from Traditional Policies and Practices

While Medicare's sheer size would provide it with significant leverage in negotiating with pharmacies and drug manufacturers, doing so would represent a departure from traditional Medicare. Medicare beneficiaries represent less than 15 percent of the population but a disproportionately higher share—about 40 percent—of prescription drug spending. However, because of Medicare's design and obligations as a public program, its current purchasing strategies vary considerably from those of the private sector.

---

[14] A pharmacy and therapeutics committee within the health plan or a PBM typically makes decisions about whether to include particular brand-name or generic drugs on the plan's formulary.

[15] Plans generally encourage the use of formulary drugs by having lower cost sharing or requiring special approval of a nonformulary drug. For example, health plans have increasingly adopted three-tiered cost-sharing strategies whereby enrollees incur the lowest out-of-pocket costs for using generic drugs, higher costs for brand-name drugs on the formulary, and the highest costs for brand-name drugs not included on the formulary.

[16] Our report compared the FEHBP plans' formularies to the Department of Veterans Affairs (VA) National Formulary, considered by the Institute of Medicine to be not overly restrictive. Each FEHBP plan we reviewed included over 90 percent of the drugs listed on the VA formulary or therapeutically equivalent alternatives, and included at least one drug in 93 percent to 98 percent of the therapeutic classes covered by VA.

- *Any willing provider*. In contrast with private payers' reliance on selective contracting with providers and suppliers, the traditional Medicare program has generally allowed any hospital, physician, or other provider willing to accept Medicare's reimbursements and requirements to participate in the program. With respect to drug purchasing in particular, private plans determine the extent of their enrollees' access by the choices they make about the size of their participating pharmacy network and breadth of their drug formulary. Allowing any pharmacy willing to meet Medicare's terms to participate or allowing all therapeutically equivalent drugs equal coverage on a formulary would restrict the program's ability to secure advantageous prices. Moreover, health plans and PBMs currently make formulary determinations privately. In contrast, Medicare's policies have historically been open to public comment.
- *Administrative rate-setting*. Whereas private health plans typically rely on price negotiations to establish payment rates, Medicare generally establishes payment rates administratively. As discussed earlier, Medicare's rates often exceed market prices and this is the case for some of the few outpatient prescription drugs covered by Medicare.[17] The program's method of paying for these drugs is prescribed in statute: In essence, Medicare pays 95 percent of a drug's "average wholesale price" (AWP). Despite its name, however, AWP is not necessarily a price that wholesalers charge and is not based on the price of any actual sale of drugs by a manufacturer. AWPs are published by manufacturers in drug price compendia, and Medicare bases providers' payments on these published AWPs. Other public and private purchasers typically use the leverage of volume and competition to secure better prices. By statute, Medicaid, the nation's health insurance program for certain low-income Americans, is guaranteed manufacturers' rebates based on prices charged other purchasers.[18] Certain other public payers can pay at rates set in the Federal supply schedule, which uses verifiable confidential information on the prices drug manufacturers charge their "most favored" private customers. Manufacturers agree to these prices, in part, in exchange for the right to sell drugs to the more than 40 million Medicaid beneficiaries.
- *Low-budget program administration*. Duplicating the type of controls PBMs have exercised over private-sector drug benefits would likely involve devoting a larger share of total expenditures to administration than is spent by Medicare currently. Medicare's administrative costs historically have been extremely low, averaging about 2 percent of the cost of the services themselves.[19] This level of expenditure may not be consistent with the level needed to review the volumes of claims data associated with prescription drugs for the elderly or acquire and maintain the on-line systems and databases PBMs use to employ such utilization controls as real-time claims adjudication. The number of prescriptions for Medicare beneficiaries could easily exceed the current number of claims for all other services combined, or over 1 billion annually.

Decisions about the Extent of Latitude and Competition Allowed Are Critical to Administering a Medicare Drug Benefit

Medicare would undoubtedly need assistance from external entities to administer a drug benefit, just as it has used insurers to process claims in the traditional program and Medicare+Choice plans to go further by also managing services and assuming risk. Decisions about the roles assigned an entity or entities and the latitude allowed them in carrying out those roles would be critical. These decisions would undoubtedly affect the benefit's value to beneficiaries and the efficiencies and savings secured for both beneficiaries and taxpayers. Some of these decisions parallel those made by FEHBP plans that I discussed—trade-offs about beneficiaries' interests in broad pharmacy networks and formularies versus potential savings. Others stem from the uniqueness of Medicare, its likely disproportionate share of the drug market, and its position as a public program requiring transparency and fairness.

Insurers and PBMs have been successful in securing some savings on drug purchases by leveraging their volume to move market share from one product to an-

[17] GAO–01–1118.

[18] Since the enactment of the Omnibus Budget Reconciliation Act of 1990, drug manufacturers are required to provide rebates to State Medicaid programs on outpatient drugs based on the "lowest" or "best" prices they charged other purchasers or a minimum of 15.1 percent of the average manufacturers' price (AMP) for brand-name drugs. Rebates must be at least 11 percent of AMP for generic drugs.

[19] U.S. General Accounting Office, Medicare: HCFA Faces Challenges to Control Improper Payments, GAO/T–HEHS–00–74, (Washington, D.C.: Mar. 9, 2000).

other. Medicare's leverage, given that purchases by the elderly constitute about 40 percent of the drug market, could be considerable. Yet the large market share may also be likely to attract considerable attention. The administration of a Medicare drug benefit could then be subject to the same intensity of external pressures from interested parties regarding program prices and rules that can often inhibit the program from operating efficiently today. The potential for micromanagement could compromise trying to use the very flexibility PBMs have employed in negotiating prices and selecting preferred providers in order to generate savings. An alternative would be to sacrifice some of the program's leverage and grant flexibility to multiple PBMs or similar entities so that any one entity would be responsible for administering only a share of the market.

Contracting with multiple PBMs or similar entities, however, would pose other challenges. If each had exclusive responsibility for a geographic area, beneficiaries who wanted certain drugs could be advantaged or disadvantaged merely because they lived in a particular area. To minimize inequities, Medicare could, like some private sector purchasers, specify core benefit characteristics or maintain clinical control over formulary decisions instead of delegating those decisions to its contractors.

If multiple PBMs or similar entities operated in a designated area, beneficiaries could choose among them to administer their drug benefits. These organizations would compete for consumers directly on the basis of differences in their drug benefit offerings and administration. This contrasts with the private sector where drug benefits are typically part of an overall insurance plan, and PBMs typically compete for contracts with insurers or other purchasers. Competition could be favorable to beneficiaries if they were adequately informed about differences among competing entities offering drug benefits and shared in the savings. However, adequate oversight would need to be in place to ensure that fair and effective competition was maintained. For example, a means to ensure that beneficiaries received comprehensive user-friendly information about policy and benefit differences among competing entities would be necessary. Monitoring marketing and customer recruitment strategies and holding entities accountable for complying with Federal requirements would require adequate investment. The contracting entities could need protections as well. Some mechanism would be needed to risk adjust payments for differences in beneficiaries' health status so that those entities enrolling a disproportionate share of high-use beneficiaries would not be disadvantaged.

Concluding Observations

Medicare's financial challenge is very real and growing. The 21st century has arrived and our demographic tidal wave is on the horizon. Within 5 years, individuals in the vanguard of the baby boom generation will be eligible for Social Security and 3 years after that they will be eligible for Medicare. The future costs of serving the baby boomers are already becoming a factor in CBO's short-term cost projections.

Frankly, we know that incorporating a prescription drug benefit into the existing Medicare program will add hundreds of billions of dollars to program spending over just the next 10 years. For this reason, I cannot overstate the importance of adopting meaningful reforms to ensure that Medicare remains viable for future generations. Adding a drug benefit to Medicare requires serious consideration of how that benefit will affect overall program spending. If competing private entities are to be used to administer a drug benefit, it is important to understand how these entities can be used in the Medicare context to provide a benefit that balances beneficiary needs and cost containment.

Medicare reform would be done best with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. Given the size of Medicare's financial challenge, it is only realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. We should begin this now, when retirees are still a far smaller proportion of the population than they will be in the future. The sooner we get started, the less difficult the task will be.

We must also be mindful that health care costs compete with other legitimate priorities in the Federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which competing priorities will be met. In making important fiscal decisions for our nation, policymakers need to consider the fundamental differences among wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.

The public sector can play an important role in educating the nation about the limits of public support. Currently, there is a wide gap between what patients and providers expect and what public programs are able to deliver. Moreover, there is insufficient understanding about the terms and conditions under which health care coverage is actually provided by the nation's public and private payers. In this regard, GAO is preparing a health care framework that includes a set of principles to help policymakers in their efforts to assess various health financing reform options. This framework will examine health care issues systemwide and identify the interconnections between public programs that finance health care and the private insurance market. The framework can serve as a tool for defining policy goals and ensuring the use of consistent criteria for evaluating changes. By facilitating debate, the framework can encourage acceptance of changes necessary to put us on a path to fiscal sustainability. I fear that if we do not make such changes and adopt meaningful reforms, future generations will enjoy little flexibility to fund discretionary programs or make other valuable policy choices.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Committee Members may have.

Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon, Director, Health Care Issues, at (202) 512–7114. Other individuals who made key contributions include Rashmi Agarwal, Linda Baker, John Dicken, Hannah Fein, Kathryn Linehan, James McTigue, Jennifer Rellick, and Melissa Wolf.

Chairman THOMAS. I thank both of you very much.

It has sometimes been said, notwithstanding the charts, that the solvency of Medicare is probably greater than in previous periods and that we really shouldn't worry all that much about it because when the pressure increases on us, historically we have always done something. One of the concerns that the Chair has is that some of the easy choices were taken early.

For example, when this Committee engages—and it will—in discussion of Social Security and the solvency of that trust fund, we are all mindful that currently the payroll tax is capped at a particular dollar amount. The HI Trust Fund already does not have the cap that could be removed.

So, notwithstanding that 2013 and 2016 still seems like some time away, do you believe we have luxury of arguing that since we probably have as great a front-loaded number of years of solvency as we have had at any time in the past, that that is a comfort that we should wait awhile over?

Mr. WALKER. We should not focus on the trust fund balance, for reasons that I articulated. I think we have three basic sustainability problems: At the lowest level, Medicare; at the next level, our health care system; and at the top level, our overall fiscal imbalance.

Chairman THOMAS. Well, I tell you that I feel a little bit about Medicare as I probably feel even more about the health care system, because frankly when you compare us with other countries—and sometimes you can't do it on an absolute base, you have to look at other humans in the human condition and what they do—it isn't so much how much we spend for health care in this country, and underscored as well for some of the government support programs like Medicare, it is how we spend it. One of the reasons we have been so concerned about wanting to try to make some fundamental modernizations or changes to Medicare is because without those, Medicare as a support structure isn't fashioned in the best way to

receive a major prescription drug addition—something as simple as the historical creation of the A and the so-called B, one from a dedicated trust fund, the other one from the general fund; and the fact that it doesn't look much like an insurance policy or any provisions that would give us comfort that some of the things that we have seen work in other systems simply won't work here by virtue of the way it was created and the failure to keep it up to date.

Throwing on a prescription drug benefit doesn't solve the underlying concerns over Medicare. Is that a fair statement?

Mr. WALKER. I think it is fair to say that if the conditions that exist today had existed in 1965, you probably would have included a prescription drug benefit in Medicare to begin with. On the other hand, you probably also would have included a number of other cost-containment mechanisms that you do not have today. So, on one hand you are talking about adding a prescription drug benefit, which most employers have added since 1965, but they have also changed their health insurance coverage in many other ways, with targeting, deductibles, copays, and things of that nature, and Medicare has not.

Chairman THOMAS. Let me just briefly, then, ask you some questions about the Medicare Payment Advisory Commission. They perform a very important role. We attempted to create a commission made up of professionals who have a broad background in health care touching any number of areas, along with some consumer advocates—who examine current conditions and make recommendations on assistance to various providers and other decisions that we need to make.

One of the major changes that was made recently was to require MEDPAC, as we call it, to vote—because they have a chance to influence public policy, we thought it might be useful to require public votes so that people could see how the interests that may represent particular areas of health care voted on particular issues. I know MEDPAC recently made 17 recommendations to the House and specifically this Committee. What I found most striking about those recommendations, that where the 17 members—I believe it was 19 recommendations—where the 17 members made 19 recommendations, if you added up all the individual votes, and of course certain things happen in the House if it is a voice vote versus a recorded vote versus how many people are in opposition, we handle issues differently based upon the votes. When you add up all the votes of MEDPAC on those 19 recommendations, there were collectively 300 ayes for the position taken, and 2 nays.

Given the depth and breadth of the professionalism and history of experience of MEDPAC, should this Committee be impressed by, ignore—how should we deal with recommendations that are presented to us by that body with a vote of 300 to 2?

Mr. WALKER. Mr. Chairman, I have tried very hard to work with this Committee and others as Comptroller General of the United States to appoint MEDPAC members. I believe that we have significantly upgraded MEDPAC in the last several years. I believe that you need to give serious consideration to the recommendations that you receive from MEDPAC. They are hampered with a problem that this Committee, GAO, and many others have in that they don't have an adequate amount of timely, accurate and

useful health care information. Their basic recommendations are consistent with the work that GAO has done, and I think that you need to seriously consider their recommendations.

I also think it was appropriate to increase the transparency and accountability of the votes associated with MEDPAC members. I think that was appropriate, given their substantial responsibilities and the sums involved.

Chairman THOMAS. Have you had any feedback from the MEDPAC members themselves about their willingness and comfortableness with the transparency in the recorded votes, as a process, as opposed to what they used to do?

Mr. WALKER. Well, initially there was some apprehension. I have not heard any concerns. I think there generally is an understanding that it was the right thing to do.

Chairman THOMAS. I thank the gentlemen. Dr. Holtz-Eakin, it is always difficult to ask a new director of CBO about estimates that have been made in the past, although I assume you have a moral obligation to accept all of the product of previous CBOs and directors. Sometimes when people focus on the debate on the floor of the House example, with amendments or substitutes to bills, the discussion is couched in ways in which people can't fairly judge or discriminate between approaches taken by various bills. One of the things I hope to do with this hearing is to at least begin the record with a clear understanding that there are consequences to choices that are made in the way you structure bills. I know this may be uncomfortable for some folk, but I don't really know any other way to begin a process of talking about building a bill without asking some fairly direct questions, and asking you if you have the ability to compare particular structures.

For example, included in the bill that passed the House last year was a provision that we called the best price policy, which would have required a degree of negotiation on discounts from pharmaceutical manufacturers without regard to an artificial so-called best price structure that is located in Medicare. I am always fearful when someone tells me they are going to give me the best price, especially if it is a structured best price.

In looking at last year's bill—and it is true, as was commented, there is no bill for the majority in yet. We are looking at these issues and want to make some decisions. In comparison, the gentleman from California, for example, Mr. Stark, does have a bill in this year—I believe it is H.R. 1199. Have you been able to score that bill yet, Doctor?

Dr. HOLTZ-EAKIN. We do not yet have a score on the bill this year. We did, in fact, do work in previous years on these issues.

Chairman THOMAS. Okay. So, we might be comparing last year's bills rather than the current edition.

Did the idea of negotiating discounts save money over a best price—first part of the question. Second part, for example, a tool that was utilized, I believe, in the previous bill, where you allow physicians to override formularies and provide an any-willing-provider structure for pharmacies. Those are two ways to deal with pricing. Can you comment on each in a comparison between them?

Dr. HOLTZ-EAKIN. With the caveat that I am new to the job and may have to get back to you with particular details, I can say

a couple of things on those issues. The first is that in looking at incentives and outcomes on cost containment, one really wants to look at incentives and the opportunity to undertake cost containment. So, with regard to the best-price provision, that leads to a greater incentive to try to negotiate a lower price from a manufacturer, and as a result, CBO did in fact, score that in previous legislation as saving about $18 billion. We would undertake to update that estimate this year. I am not sure exactly what the precise number would be.

With regard to physician override, that clearly limits the ability to control costs and to undertake the control of the lowest possible source of a pharmaceutical. As a result, it would lead to higher costs, other things being equal.

Chairman THOMAS. One of the debates, and I am sure it will ensue again this year, over models that might be constructed is the idea of creating a catastrophic or so-called stop-loss structure, where there is some exposure which most people believe that if you have copayments or other arrangements in which beneficiaries share in the costs, that there might be some savings over the long run by decisions that are made in part because of out-of-pocket costs in which the beneficiary is not insulated from all costs associated with the cost of pharmaceuticals.

We provided a structure in the last bill which created a stop-loss arrangement. My understanding is, again comparing two specific solutions to in essence the same problem, that H.R. 1199 has a very low stop-loss structure, which might deal with so-called—price induction, is the phrase that is used—if you are dealing with, say, a $2,000 catastrophic as opposed to the structure that we had offered.

What is your analysis of those different approaches to the question of exposure of beneficiaries to costs in an overall attempt to reduce the exposure to the Medicare trust fund?

Dr. HOLTZ-EAKIN. Well, I again go back to the rules of thumb, which are incentive and opportunity. To the extent that beneficiaries have an incentive to control costs, you will get greater cost savings. Regarding larger subsidies, other things being equal, if you subsidize 90 percent of any insurance product versus, say, 70 percent, the larger subsidy will lead to a lower incentive to control costs and will lead to higher prices and higher spending.

Chairman THOMAS. So, the idea of an assistance to individuals to shield them to any cost exposure ironically would wind up with an overall higher price because the so-called incentive that was there is no incentive at all?

Dr. HOLTZ-EAKIN. The key thing is to look comprehensively. To get total costs, you want to look comprehensively. So, you would want to look at incentives and opportunities for individuals as well as for providers. Focusing on the individual's part, having limited incentives to control costs will lead to higher costs and higher prices.

Chairman THOMAS. Then the bottom line of all of this questioning is that last year the bill that passed the House, along with the modernization of prescription drug and provider portions, cost somewhere in the vicinity of $350 billion, I believe, and the bill

that was purported to meet essentially the same argument from the minority's perspective cost what in last year's dollars?

Dr. HOLTZ-EAKIN. The CBO score last year was roughly $970 billion.

Chairman THOMAS. So, $350 billion to $970 billion. Of course that is the direct result of having a catastrophic, which in fact does not induce the appropriate behavior and therefore costs more and does not have competition, such as we indicated in not accepting some formulaic best price but rather requiring actually a negotiated process to produce best price.

These are the kinds of questions that I think are important to understand why bills contain certain provisions. When you add up all the particulars, it does produce a product that either brings about particular results at a cost that is afforded under a budget proposal, or you get something that is up to three times as expensive and, ironically in terms of the way it is built, produces cost increases rather than cost savings.

With that, I want to thank both of you for what you have done and, obviously as we move into a more formal discussion of solutions, what you are going to do for us. Does the gentleman from New York wish to inquire?

Mr. RANGEL. Thank you, Mr. Chairman. Let me thank both of you for pointing out expertly the degree and the serious nature of the problem. Am I to assume that both of you studied the House-passed bill in preparation for your testimony today?

Dr. HOLTZ-EAKIN. I am familiar with the House-passed bill. I would not say that I am intimately familiar with all the details.

Mr. WALKER. I am somewhat familiar with it, but I did not study it before today.

Mr. RANGEL. Well, have you been privy to any draft of a bill that the majority intends to offer for our consideration at some point in time in the future?

Dr. HOLTZ-EAKIN. We have to date not scored any particular bills at CBO. We have talked at the staff level in discussions about ideas, and no more.

Mr. WALKER. I have not seen any proposed bill or framework for a bill.

Mr. RANGEL. Do you think that professionally you could be of better assistance to this Committee if you had before you a bill as to the direction that we were going?

Dr. HOLTZ-EAKIN. It will in the end be the Committee's judgement whether I am of assistance or not. I will tell you that, in our experience at CBO, the details of proposals do in fact matter a great deal, and the greater specificity of an actual bill allows us to give a more precise answer, without question.

Mr. WALKER. Obviously if you have a specific proposal, you can make more targeted comments as to what the likely pros and cons of that proposal are.

Mr. RANGEL. That makes a lot of sense to me. I get the impression from the past conduct of this Committee that we are seeing both of you for the last time on this subject matter.

[Laughter.]

Mr. RANGEL. Not having the slightest clue as to which direction the majority is going to take us, we may ask you, in an impartial

way, to meet with—if we don't have a formal meeting, to share your opinions of whatever comes from the majority, wherever it comes from, so that we might be able to again visit with you and have a better understanding of the impact of the decisions that we will be making. I do hope that before we vote on this bill, assuming the bill comes back to this Committee and not go straight to the suspension calendar, that we would have an opportunity to discuss this further.

Let me thank you for this meeting, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. I think you will find that oftentimes the most useful examination of an issue is in comparison with alternatives rather than examining it in some absolute environment, because then you have the opportunity to weigh real choices between real alternatives. The Chair hopes that as a plan is presented from the majority side that we will have an opportunity to examine one from the minority side as well.

Does the gentleman from Illinois wish to inquire?

Mr. CRANE. Thank you, Mr. Chairman.

Now, Mr. Walker, I have in front of me the GAO Medicare Hospital Insurance Trust Fund projected deficit between 2010, starting roughly 2010 going on into 2040. Is that projection based on constant dollar value?

Mr. WALKER. Yes, 2003 dollars. So, it is adjusted for inflation. It is the HI program alone. It does not include SMI.

Mr. CRANE. The reason I ask that is I came to Congress in 1969 and the dollar is worth about 10 cents today of what it was when I came here. You have a 30-year period here, and that 30-year period would result in a $300 billion deficit. Is that a $300 billion probable deficit or a $3 trillion deficit?

Mr. WALKER. No, it is a $300 billion, based upon 2003 dollars. So, in other words——

Mr. CRANE. I know, constant dollars.

Mr. WALKER. That is correct.

Mr. CRANE. Would you honestly expect that to happen?

Mr. WALKER. Well——

Mr. CRANE. How would you expect that to happen based on our performance here for the last 35 years?

Mr. WALKER. We rely upon the trustees' assumptions as to what they expect inflation is going to be when we end up coming up with the discount factors. I think if you look in the past at how the trustees have done in projecting what cost will be, if anything, their intermediate assumptions have been low, not high. So, I think it is a realistic picture, and I think the bottom line is it shows you have a serious problem.

Mr. CRANE. Well, I remember when we worried about billions and now we are talking trillions, and it will be quadrillions in another 30 years at the rate we are going. Governments always have a way of resolving those problems by just escalating the quantity of money out there. That is something that has me troubled about any of these kinds of projections, based upon our performance over the past generation.

Mr. WALKER. What I would suggest, Mr. Crane, if you also looked at it as a percentage of the budget or as a percentage of the

GDP, which we also presented information on, that may be a more useful way for you to look at it. Either way, it is a problem.

Mr. CRANE. Oh, yeah. Oh, no question about it, it is a problem.

I would like to also ask you, Mr. Walker, in your testimony you say GAO's long-term budget simulations show that absent meaningful entitlement reforms, demographic trends and rising health care spending will drive escalating Federal deficits and debt. Neither slowing the growth of discretionary spending nor allowing the 2001 tax reductions to sunset will eliminate the imbalance. Given these estimates, it seems that it will be difficult to modernize Medicare that includes prescription drugs. If a modest drug benefit program that costs $400 billion is going to be hard to create due to budget constraints, wouldn't a $1 trillion plan be next to impossible without massive tax increases, slashing other valuable Federal programs, cutting provider payments, and forcing seniors to pay large premiums and deductibles?

Mr. WALKER. I think it is important, whether you are dealing on the spending side or the tax side, that you look at not just the 10-year costs but also the long-range implications, including discounted present value amounts. Obviously, to the extent that you are talking about adding a benefit that costs a lot more money, that is going to worsen the long-range imbalance. We look at the bottom line, what is the bottom line.

Mr. CRANE. One final question I would like to put to you, either one or both of you, and that has to do with the recognizing Medicare's current benefit costs are escalating and to obtain ideas from CBO to slow that cost growth. The CBO projects that, absent any change in the law, annual spending on Medicare will more than double in 10 years to nearly $460 billion. An analysis by the Centers for Medicare and Medicaid Services Office of the Actuary demonstrates that Medicare spending last year spiked dramatically. What recommendations have you regarding controlling costs of the current program, and have you examined the recent MEDPAC recommendations and what do you think of those?

Dr. HOLTZ-EAKIN. Congressman, it is not CBO's role to make specific recommendations on how to control Medicare costs. I would be happy to discuss with you the implications of adopting any of the MEDPAC recommendations. We look forward to working with you on that.

Mr. CRANE. Very good. Thank you. I yield back the balance of my time.

Mr. MCCRERY. [Presiding.] Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I want to thank the witnesses. Mr. Walker, I wonder if you could comment on the effect on Medicare if the tax cuts were not extended and, instead of repealing the estate tax, we had merely gone with a fairly large exemption, say $3 or $4 million, as was suggested in an alternative plan; and that the taxes would rise as a share of the GDP. What kind of doomsday scenario—how would that change it, in effect?

Mr. WALKER. We have done an overall budget simulation under several sets of assumptions. One set is the tax cut does not sunset; the other assumption is that it does sunset. Obviously, if it does sunset, then that makes the gap less in the outer years. At the same point in time, it does not come close to closing the gap. There

is still a long-range problem irrespective of what the Congress decides to do there.

Mr. STARK. Is the difference in those 2 scenarios about 25 years till implosion or explosion, is that correct?

Mr. WALKER. It makes a bigger difference when you are starting to deal with the 2030 to 2050 period. You know, either way, you have really escalating deficits, but the timing in which you start seeing those deficits, obviously, is different.

Mr. STARK. Did you do any studies on the change needed in the—if you assumed that we did not extend the 2001 tax cut or the inheritance tax demise, what kind of a payroll tax increase would be needed to——

Mr. WALKER. We didn't do that. We looked at the larger fiscal picture, which is what the long-range budget simulation is intended to be. Mr. Stark, the trustees' latest report for 2003 would show that if you wanted to solve the problem merely through increasing the tax rate for HI, you would have to increase the HI tax rate by 83 percent today in order to solve it just through that. That would only solve it for the next 75 years. Every year we have a big deficit beyond the 75 year horizon that has to be dealt with.

Mr. STARK. Well, I might ask the same question, Dr. Holtz-Eakin. It is my understanding that we could pass the 75 year solvency test—which we have never achieved, I might add—if we increase the payroll tax by about 1.2 percent on both sides. Is that a number with which you gentlemen would concur?

Mr. WALKER. Yes, 2.4 percent of taxable payroll. You are correct, 1.2 percent on each side, which would be an 83-percent increase.

Mr. STARK. In a sense, that would pretty much solve, given what we know now about the increased spending on health care, that would solve this problem financially speaking for all time.

Mr. WALKER. No, it does not.

Mr. STARK. Seventy-five years.

Mr. WALKER. That solves Part A, HI, for 75 years; it doesn't do anything about SMI, it doesn't do anything about the broader health care challenge or the long-range fiscal problem.

Mr. STARK. Okay, so that is on the HI and the Part A side. The worst-case scenario for 75 years, which is about as far ahead as we care to plan. That is fair. Now, how much would it take in—have you then to solve the Part B side to provide enough additional general revenues to cover the 75 percent that we fund now. If this were done, how much more than not extending the 2001 tax cut and not eliminating the inheritance tax, how much more revenue would that—My understanding, that this total tax cut, including the interest cost, is about a $2 trillion loser.

Mr. WALKER. Well, first, I think it is important——

Mr. STARK. Is that correct?

Mr. WALKER. I don't have the number. I can provide it for the record. I can tell you that—in fact CBO would probably be the right place to get that number, since they are the ones that are supposed to be doing the projections. I——

Mr. STARK. Give it to CBO.

Mr. WALKER. I would say for the record, though, Mr. Stark, that the 2.4 percent is not worst-case. That is based on the inter-

mediate assumptions. The trustees have low-cost, high-cost, and intermediate cost estimates. So, it is not worst-case, and again, it only deals with HI, not SMI.

Mr. MCCRERY. Before——

Mr. STARK. Could I—Mr. Chairman, I just the indulgence to hear Dr. Holtz——

Mr. MCCRERY. If Dr. Holtz-Eakin would like to answer, that is fine.

Dr. HOLTZ-EAKIN. Briefly, I am not privy to the simulations that Mr. Walker has discussed. In the chart that I showed you, what we displayed was a rise in Medicare costs from about 2.5 percent of GDP to in excess of 9 percent of GDP over the 75 year horizon you are discussing. Those costs will have to be financed somehow. Spending is ultimately a burden on the economy. I would also point out to you that these are projections made under the assumption that health care costs rise 1 percentage point faster than GDP. Historically, Medicare costs have risen 2.8 percentage points faster than GDP. So, these projections actually contain the assumption that there will be steps taken to bring cost growth down. To the extent that that does not happen, these numbers would be, in fact, dramatically larger than the estimates that are in my written testimony. The particulars of the financing which you have been discussing, I would argue, are secondary to the ultimate observation that the outlays will rise as a fraction of the economic resources in this economy that are available to finance those programs and any others.

Mr. MCCRERY. Dr. Holtz-Eakin, do these numbers include the addition of a prescription drug benefit?

Dr. HOLTZ-EAKIN. No, they do not.

Mr. MCCRERY. How much difference would it make if we were to add a $400 billion or trillion——

Dr. HOLTZ-EAKIN. We would have to do a careful set of estimates. I would be happy to work with you on that. Four hundred billion dollars is roughly $50 billion a year over the 8 years of the budget window in which a drug benefit would be in effect. That is a number that is well under 1 percent of GDP. However, as I pointed out in my remarks, prescription drug spending has been growing more rapidly than Medicare spending as a whole, and so the long-term outlook would certainly be worse, other things being equal. The precise numbers—we could work with you to develop an estimate.

Mr. MCCRERY. Mr. Walker.

Mr. WALKER. I would hope that there would be an effort to come up with what would be the discounted present value of what the cost of the program would be, not just looking at the 10-year numbers, because they can be very misleading. I think it is important to look beyond that, because we don't really start to hit the major part of the demographic tidal wave until beyond the 10 year point. Therefore, you can get a false sense of security if you just looked at 10-year numbers. They can explode beyond that.

Mr. MCCRERY. Mr. Shaw.

Mr. SHAW. Mr. Walker, I want to go back to a point that you covered in your testimony. This goes back to the first graph that you had up there, in which you talk about Medicare going into a

cash deficit in the year 2013. In that regard, of course, we have Treasury bills that are in there, and they won't be exhausted until what year?

Mr. WALKER. The year 2026 is when the special issue Treasury securities will exhaust.

Mr. SHAW. Does the fact that we are going through the process of cashing in Treasury bills, do they have any real economic value to the program?

Mr. WALKER. I am not a Ph.D. economist, but I would say no, they don't have an economic value. They have a legal significance, they have a moral significance, they represent a priority claim on future general revenues, but they do not have an economic value.

Mr. SHAW. You may not be an economist, but you are certainly a well-versed certified public accountant (CPA). As such, you certainly know the difference between a real economic asset and one that is not. I certainly accept your explanation. So, what you are talking about and what you are telling this Committee is that 2013 is the year in which, really, the system is going to have to—we are going to have to find other ways to pay benefits if we are going to keep taxes at their present level and not cut benefits. Is that correct?

Mr. WALKER. Correct. You are either going to have to raise taxes, cut spending, or go into more public debt financing in order to convert these bonds into cash.

Mr. SHAW. Now, the same thing applies to Social Security, doesn't it? What year is that?

Mr. WALKER. I believe it is 2018, Mr. Shaw.

Mr. SHAW. It just changed recently, and I believe you are right. It was 2016. I think it has been changed. So, the same thing applies in Social Security, where there are not real—those Treasury bills are no real economic assets. It is simply evidence of a moral obligation that a future Congress is going to have to figure out how they are going to pay the benefits and how they are going to pay off those Treasury bills. Is that not correct?

Mr. WALKER. That is true, and personally I think that Congress has a stewardship obligation. You need to look beyond just today. You need to look to future generations and what type of burdens are being passed on to them.

Mr. SHAW. So, I guess regardless of what particular road the Congress may decide to go on eventually, we are going to have to, if we want to do something, we are going to have to start building up in some way real economic assets that the Social Security Administration as well as Medicare will have some type of a call on, unless we drastically restructure the system. Is that not correct?

Mr. WALKER. Well, we are going to have to do something. There are different ways to reform Social Security and Medicare. The fact is, the Medicare problem is multiple times worse than the Social Security problem.

Mr. CRANE. Will the gentleman yield?

Mr. SHAW. I yield.

Mr. CRANE. Is not one alternative solution also to increase the money supply?

Dr. HOLTZ-EAKIN. No, sir. Over the long term, what will serve as resources to pay these obligations of the Federal Government

and finance the private sector as a whole will be the real (inflation-adjusted) economic resources. Those will develop independently of movements of the money supply in the short term.

Mr. CRANE. Well, no, my point is that is what we have been doing for the last 30 years, is just increasing the money supply. We have a steady erosion of the integrity of our dollar, and we have had it going on for 30, 35 years.

Dr. HOLTZ-EAKIN. The evolution of inflation in the United States is certainly one that we can discuss at length. I would point out that in both the presentations we have adjusted for that. We have taken out the inflation components and have isolated just the part that has to do with real economic growth.

Mr. CRANE. Oh, I know you have in your projections, but what I'm saying is that is one of the alternatives that, sad to say, government can fall back on.

Mr. SHAW. Let me reclaim my time, as it is about to expire. Again, as Mr. McCrery asked, on the previous chart that was up there, you have not built in any prescription drugs into your prediction?

Mr. WALKER. No, this is the current program. It does not include any potential prescription drug benefit.

Mr. SHAW. I thank you both for your testimony. I wish you could have brought us better news, but you have to tell us what you think and there is no sense in going after the messenger because the real problem lies with us right here. Thank you. Yield back.

Mr. MCCRERY. Mr. Shaw makes an excellent point about the savings that we have in the trust fund. To make it crystal clear, it is kind of like me telling myself I am going to save for my son's college education, and I am going to save 3 percent of my income. I write a check for 3 percent of my income, but instead of putting it in savings, I spend it on a car or a house or whatever and I write myself an IOU and put it in the drawer. So, that when my son gets to college age, I take those IOUs out and spend them on his college education. Well, clearly, I have to come up with the money somewhere to pay those IOUs.

Mr. SHAW. Or he doesn't go to college.

Mr. MCCRERY. Or he doesn't go to college. So, it is an excellent point that Mr. Shaw makes. It is not the trust fund that we need to worry about so much as it is the cash flow.

Mr. Levin.

Mr. LEVIN. Welcome. I was going to ask you about deficits, but I have decided not to do so. It is interesting that people shift in terms of their attitudes toward deficits. When it comes to tax cuts, we have been hearing deficits don't matter. Then some of the same people who said that, when it comes to their desire to restructure Medicare, deficits are supremely important. It seems to me there needs to be some consistency in position. Some of us who have thought deficits have mattered and acted that way for the last 20 years have tried to be consistent.

It is also interesting, when it comes to estimates, there is also kind of the same pragmatic approach, to put it charitably. When people want to accomplish a certain purpose—in this case Medicare and restructuring it—they talk about these estimates as if they are

divinely decreed. Then, if they are defending a so-called growth package, they say what Mitch Daniels said just a month ago or 2 months ago, that these estimates, 10-year estimates are not just flawed but wildly misleading, to quote him exactly.

So, I think I won't pursue these issues here, but just talk about a few other things. By the way, in terms of projection in Medicare spending—maybe this isn't fair to the new Director, but I think CBO's estimates on Medicare spending the last 6 or 7 years, as I see the data, those estimates have not been very accurate, have they? They have overestimated actual spending in their projections. Or maybe you don't have that data.

Dr. HOLTZ-EAKIN. I don't have the history in front of me. I will be happy to provide the history, if you would like that. I will point out that in doing its projections, CBO is constrained to project current law. In those circumstances, if after the projection is made the Congress chooses to alter physician payments or other attributes of the Medicare program, we will of necessity have our numbers be wrong after the fact. It is the nature of the projection process. We can happily go back and examine the history and find those situations where we might be able to improve it, given that we are constrained to project current law.

Mr. LEVIN. Okay, if you would do that and provide us the information. I don't mean to minimize the problem for 1 minute. I just think there needs to be a consistency and we should not be using these figures to suit our particular purpose and then the next week take the opportunity position.

Let me ask Mr. Walker about your statements on page 2 about Medicare's overly generous rates. I just saw some material from southeast Michigan hospitals that talked about $40 million losses. Would it be possible—I am not sure this is within your authority—for you to come to Southeast Michigan and sit down with the hospitals and determine what the true picture is? Is that something consistent with your——

Mr. WALKER. Well, Mr. Levin, I don't know that it is consistent. I would be happy to talk to you about what may or may not be appropriate for us to do. The reimbursement rates can vary based upon the type of provider involved, the locality involved, and a variety of factors. So, we have to be careful when we talk about averages because there can be significant variances from averages.

Mr. LEVIN. Okay, let us do that. By the way, when you talk about overly generous rates for certain services and products, has that applied in some instances, some substantial instances to reimbursements or payments to Health Maintenance Organizations (HMOs), to managed care organizations?

Mr. WALKER. We have reported on that, we have reported on skilled nursing, and a variety of things——

Mr. LEVIN. You have reported on overly generous payments to HMOs?

Mr. WALKER. We have done some work on that and I would be happy to provide it to you.

Mr. LEVIN. Thank you.

Mr. WALKER. Again, one has to be careful, because there can be big variances from the average.

Mr. LEVIN. That applies to HMOs, to various payment structures, right?

Mr. WALKER. Correct.

Mr. LEVIN. Thank you.

Mr. MCCRERY. Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Chairman, and thanks to both of you for laying out very clearly and quite starkly the problem that confronts us with the entitlements. It is absolutely clear that we have to add prescription drugs to Medicare with that information in mind. It would be very helpful, because Members on both sides of the aisle, whether they are on this Committee or the Committee on Commerce, in this body or the other body, whether on the major Committees or off the major Committees, are trying to think this through. I think it would be helpful if you took the charts that you did for us today, the primary ones having to do with out-year growth, and accommodated them for the assumption of $400 billion spent on increase in Medicare spending for the drug bill, 500, 600, 700, 800, 900, and a trillion. There was a trillion-dollar proposal last year that had some significant Members behind it, and all Members on both sides of the aisle need to see what the out-year impact of those different breaks would be.

Then you both testified in one way or another to the minimum tools that Medicare has to control spending. So, it would be very useful if you could kind of do an analysis for us of the major plans, taking primarily the other body's Democratic plan—because I think it is fair to say it was the best developed. Now, that may not be true, and I would certainly allow my Democrat House colleagues to determine what plan you should take. For instance, our plan last year had a lot of tools in it. Some of them were very controversial. We need to see what impact those tools would have on spending growth.

For example, we allowed negotiating below the best price. The CBO gave us $18 billion credit for that. We required people to actually spend their own money to reach the catastrophic threshold—not they're employer's money, not their insurance company's money, their own money. That actually, I think, saved us, as I recall, $40 billion.

So, Members on both sides need to see what are some of the tools that are employed in the major bills that are out there to control spending, and what has been the consequence. For example, if you write the premium in law, then you no longer have the ability for efficient plans that negotiate a better drug benefit for lower cost, to be able to charge less. You know, what are the implications of that?

So, I think we need to get a better grasp, I think all Members need to have at their disposal a better grasp of what you can do. What happens if you change Medigap law so that Medigap is not allowed to cover the deductible and copayaments in Medicare? My understanding is that one tool that has worked is first dollar responsibility.

So, I would like you to comment on particularly tools that we don't have in Medicare that you think it would be advisable for us to consider having because of their impact on cost growth. As you

comment on that, I would remind you, Dr. Holtz-Eakin, that we sent you a letter about prescription drugs and specific drugs that if people take they stay out of the hospital, they don't get in an emergency room, they don't even see the doctor as much. Where are we in the science—and you might want to comment on this, too, Mr. Walker—the science of being able to determine what portion of the prescription drug effort will actually reduce hospital and other costs, and how could we structure our bills to focus on those drugs in those diseases that are most likely to have the effect on the rest of the plan of reducing costs. Are any of you doing any analysis on the small percentage of seniors that have five chronic illnesses and are eating up the majority of the money, and how would—so that you can begin helping us think through, how do we focus on that? If we focus on the people with chronic illnesses, with five chronic illnesses, we should be able to reduce costs and at the same time improve quality of care.

So, I have just laid out some tools here. We will be sending you—in fact, I delivered today to you, Dr. Holtz-Eakin, a binder on the issue of chronic disease management and if we are able to feed in the seniors that meet that criteria, do we have a potential, and what is that potential in dollar amounts, to constrain cost growth and at the same time improve the quality of care.

So, what ideas would you commend to us, what tools would you urge us to give Medicare to bend this cost curve?

Dr. HOLTZ-EAKIN. Well, Congresswoman, if I could take those in reverse order. First of all, thank you for the information you provided to CBO. We will add it to the wealth of studies that we are examining.

With regard to the ability to identify high-cost patients in Medicare, we are looking at the degree to which those high-cost patients are high-cost patients not just for 1 year, but for many years thereafter, and also, the degree to which they are identified with particular diagnoses and chronic illnesses. These are areas of active study at CBO. We look forward to working with you. We have not yet reached firm conclusions on the ability to move forward with a specific program to identify individuals and estimate cost savings from those kinds of approaches, but it is certainly under study.

On the question before that, the degree to which prescription drugs will lower costs elsewhere, we have investigated this at some length. To date, while there are cases of specific diagnoses—particularly heart disease—where one can identify a tradeoff between prescription drugs and traditional therapies, on balance, the peer-reviewed literature and the research community has not yet reached any kind of an indication that we get an overall saving from providing prescription drugs. It is an area in which CBO has a lot of interest, and we will continue to study it.

On your first question regarding tools for cost containment, I would point you to the broad mantra of incentives and opportunity. To the extent that a prescription drug provider has incentives to control costs by being at risk for the insurance risk in a program and has tools available—opportunities to control costs by negotiating with manufacturers, by picking a single drug out of a class of drugs, and a variety of mechanisms of that type—one will get better cost containment from providers. The same lesson would

apply on the beneficiary side as well. I would be happy to work with you on the particulars of those lists.

Mr. WALKER. Mrs. Johnson, we have already done a fair amount of work on this and we have other work under way. We look forward to working with you and others on it.

I think you make a good point. The Congress may well decide that it wants to update Medicare to include a prescription drug benefit because, had you designed Medicare today, you would undoubtedly have included a prescription drug benefit. However, it is also important to learn the lessons from what has happened since 1965 in the design of insurance, of health insurance. You need to learn those lessons and try to design this benefit in a way that provides incentives to control cost. I think you also, frankly, in time are going to have to do the same thing for the whole Medicare program. I think you are going to have to fundamentally reassess the entire Medicare program because as it is presently designed it is unsustainable. We don't have the right type of incentives, transparency and accountability mechanisms in place, and you are ultimately going to have to do it for the whole program.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Mr. MCCRERY. Dr. McDermott.

Mr. MCDERMOTT. Mr. Chairman, I think we ought to have some truth in advertising here. This says this is going to be a Committee hearing on expanding coverage on prescription drugs. We don't have any plan before us, neither one of the witnesses are talking about a plan that anybody is putting forward. So, I think what we are talking about is how to get rid of Medicare. So, I want to talk a little bit about Medicare.

Mr. MCCRERY. You may proceed.

Mr. MCDERMOTT. Dr. Reinhardt in his testimony suggests that there is data from the Dartmouth Study that in Texas they spend $9,000 per patient, or in Miami, $7,800 per patient, and in Oregon they spend $3,600 per patient. Now, there is a recent study that came out of the group up at Dartmouth that suggests there is no advantage, health-wise or satisfaction-wise, from either a double or a triple expenditure in Miami. Where are you with a proposal? Now, I say that I look at what happens with doctors' fees, where we have set a global budget, and we said we were going to control how much money and therefore we figure out through the scheme how much we are going to pay. The thing we didn't control was utilization. Utilization is out of control.

The same is true in the South, or in many parts of the country. I wouldn't just say the South, because it is not only in Baton Rouge and in Miami that you get these big expenditures, but it is other places. What you find is, it is longer hospital stays and it is more specialists seeing patients.

I come from a place where if we were running a health care system like the State of Washington or Oregon or Minnesota, there would be no Medicare problem here. I wonder what you guys have as suggestions of how we fix the present system. What answer do you have to the utilization problem? We get as good results in Washington State as they get in Miami and Baton Rouge, for less than half the amount of money.

Now, what is the solution? You are both supposed to have some ideas here for us, how we are supposed to fix the Medicare plan.

Dr. HOLTZ-EAKIN. You are first.

Mr. WALKER. Well, first let me say there are probably four things primarily driving the overall cost. There's the number of persons involved; inflation—both overall inflation, and then health care costs in excess of that; there is utilization, which you properly point out; and there is intensity, the intensity of care. All these factors end up increasing the top line on health care costs.

I would respectfully suggest, for any system to work, whether it be health care, whatever system it is, you have to have incentives for people to do the right thing, including controlling cost, reasonable transparency to make sure somebody's looking; and appropriate accountability mechanisms if somebody tries to abuse the system. I would respectfully suggest our Medicare system does not meet any of those criteria. I would be more than happy to provide some information for consideration by the Congress.

Mr. MCDERMOTT. I realize you have made a diagnosis, but what is the cure? Tell me the economic—see, I am not an economist like you guys are. I don't understand dollars and cents. So, I am looking to you to tell me what mechanism you put in place for this incentive program.

Mr. WALKER. Well, for one thing, I think that ultimately the Congress is going to need to reconsider fundamentally what is the promise. What is the promise in Medicare? Let me give you an example.

If you look at health care, there are several important elements. One is guaranteed access at group rates. The second is the affordability of that. The third is protection against financial ruin due to catastrophic illness. There is room in-between. You can have guaranteed access to insurance at group rates. You could end up providing significant protection against financial ruin. You could end up having more cost-sharing, which is where you need more cost-sharing. Where you don't have enough incentives to control cost. I also don't think that we have adequate, timely, and useful information to analyze what is going on out there. The data that we have for health care is often 2 and 3 years old. Health care is a huge percentage of our economy. A lot of the data that MEDPAC and you have to rely upon to make decisions is old data and it is provided by providers, who have a fundamental conflict of interest.

So, I would be happy to be able to provide some information for you to consider. It would be a fundamental review and assessment of the current system. You need a comprehensive review but will probably need to act incrementally.

Mr. MCDERMOTT. Do you think the 52 percent that beneficiaries already pay is not enough incentive to control cost? Do you think that they are the ones—is that who? It sounds like they are the ones that you think ought to be controlling the costs, not the professionals.

Mr. WALKER. No, I think there is clearly room, both on behalf of those who are being paid as well as the beneficiaries. So, I don't think it is one side or the other. I think there are issues both ways. I would be happy to have a conversation with you about it. It is a large subject.

Mr. MCCRERY. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman. Thank you, gentlemen.

Dr. Holtz-Eakin, I just want to try to get my arms around Medicare spending, putting it in a contextual basis, if you will. You stated that your projections show at CBO that overall Medicare spending is expected to quadruple by the year 2075 to more than 9 percent of GDP. I believe that the assumption was that we make no major changes to Medicare. Today the size of our GDP is roughly at $10 trillion. What does CBO estimate the GDP to be in 2075? If it is $10 trillion today, what is it going to be in 2075?

Dr. HOLTZ-EAKIN. That is a number we could get for you. It is going to grow over the long term at an average annual rate of somewhere between 3 percent and 3¼ percent, and over long periods that will add tremendously to the overall size of the economy. I can get back to you with the precise number.

Mr. RAMSTAD. Yeah, because I would like to know if we don't make changes to Medicare, then according to your statement one can deduce that Medicare spending in 2075 would be 9 percent of——

Dr. HOLTZ-EAKIN. A very large number.

Mr. RAMSTAD. A very large number.

Dr. HOLTZ-EAKIN. We can get both large numbers for you, if you would like.

Mr. RAMSTAD. Okay. I think that context is important, certainly. Then to follow up your colloquy with Mrs. Johnson, did I understand you to say that a prescription drug benefit for Medicare seniors should not be enacted without overall Medicare reform?

Dr. HOLTZ-EAKIN. In the end, the Congress will decide the best path to go forward. My discussion with Mrs. Johnson was about the extent to which prescription drugs—the introduction of prescription drugs into a therapy—would provide cost saving elsewhere in the medical system. The evidence thus far does not indicate automatic cost saving so that you get an offset from traditional therapies when you introduce prescription drugs.

Mr. WALKER. I said that I believed that it would be prudent to address both at the same time.

Mr. RAMSTAD. That is right, it was your colloquy with Mrs. Johnson. Excuse me.

Mr. WALKER. That is correct, that it would be prudent to engage in reforms of the program, not just to add on a prescription drug benefit. Congress ultimately can do whatever it wants, whether it is prudent or not.

Mr. RAMSTAD. Again, Mr. Walker, asking you the question, is it a fair assessment of your statement that a prescription drug benefit for Medicare seniors should not be enacted without comprehensive Medicare reform?

Mr. WALKER. My statement says, first, that I think it is evident that you are going to do something on prescription drugs, and it is arguably needed at this point in time. You should be careful about how you design that program, and you should also couple it with more comprehensive reforms—not just make the long-term situation worse.

Mr. RAMSTAD. That certainly is responsive to the question. I very much appreciate that answer. I think that is what most of us believe, at least on this Committee, that to do it without the context, not within the context of overall Medicare reform is making a serious mistake, for the reasons you cited and alluded to.

I just want to ask in my remaining couple of minutes, Dr. Holtz-Eakin, let me also say that I think Congress is fortunate to have an economist of your caliber at the helm. You do not have an easy job, either one of you gentlemen, and we appreciate your good work.

Most of us, I think, who support a prescription drug benefit for seniors do see a cost saving to Medicare. Won't there be a cost savings if seniors have greater access to prescription drug therapies rather than the more—what is documented is more costly and intrusive inpatient and outpatient treatments that are currently covered by Medicare?

Dr. HOLTZ-EAKIN. While I applaud your intuition, in the end, when we do the cost estimates, we rely on the evidence that is available in the research community as a whole. While we have found specific instances in which there are cost savings, as a broad statement for the health care system as a whole, there is not evidence yet that that is taking place. So, I cannot offer that hope to you.

Mr. RAMSTAD. Well, you are right. My intuition is based more on anecdotal experience than empirical data. I would like to see the study you allude to.

Dr. HOLTZ-EAKIN. We will be happy to work with you on that and would look forward to any information you might be able to provide to CBO.

Mr. RAMSTAD. It just seems counter-intuitive to me, but again, I defer to your empirical data. I would like to see those studies, if I could.

Mr. WALKER. If I can, the evidence is that is not the case. The evidence is, is that but for a few exceptions where there may be a savings, that he has referred to, that in the aggregate there is not a savings.

Mr. RAMSTAD. Again, to me that seems counter-intuitive, but I would like to explore that further. I thank you very much for being here today and your responsiveness to my questions.

Mr. MCCRERY. On the next panel we have some health care economists, so maybe they can explore that with us at greater length. Generally, I think the response given by the two witnesses before us comports with what we have been told by health care economists before. Maybe part of the reason for that is that most of the medical expense for seniors occurs in the last 6 months of their lives. Regardless of the fact that we give them preventive care or medications or whatever, eventually they are going to get sick and die, and that means they are going to have the last 6 months of life which is going to be expensive. So, quality of life is one thing, but saving money is another. I am not sure the evidence, unfortunately, points to significant, if any, savings because of preventive care or a health care regimen.

Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. I have a few concerns. Let me start with Mr. Walker. Could we put that chart back up on the trust fund deficit?

My question, Mr. Walker, is if I were preparing a net worth statement for myself, I would naturally list the cash, right? If I had a promissory note due me, would that be listed as my asset?

Mr. WALKER. If it was a good promissory note, yes.

Mr. KLECZKA. No, don't—good, bad, indifferent. It is a promise we made. We will make the judgment, not you. If it is a promissory note, that would be part of my asset base and end up in my net worth, would it not?

Mr. WALKER. Yes, it would be considered.

Mr. KLECZKA. Okay, that is why I think this chart is very disingenuous, to say the least, because you might contend that cash is king, but nevertheless it is not a true picture of the entire net worth of the HI Fund. The fact that we have promissory notes in the fund is Congress' doing. At the time the cash, King Cash, is running out, this Congress or whatever Congress is going to have to make the judgment whether or not to make it whole. By presenting this chart, and your comments, you indicate, well, the money is gone, folks, and let us not kid each other, Congress is not going to raise taxes to replace it. You know, that is a decision we will make, not the comptroller general or the GAO.

In 2013, if I were to include the trust fund balance, the money that is in treasuries, what would be the actual fiscal portrayal? In 2013. Right now you have it at almost zero.

Mr. WALKER. No, at 2013, what happens is you have—the annual income that you get from payroll taxes and other revenues is not adequate to pay current benefits.

Mr. KLECZKA. I am fully aware of that. Now, we have been amassing a balance over the years because we saw this day coming years ago.

Mr. WALKER. That is correct.

Mr. KLECZKA. There is in fact a surplus. You chose not to reflect it because you are only doing a cash portrayal here.

Mr. WALKER. No, I have reflected it. If you want to use real accounting here, Mr. Kleczka, real accounting, it is a $6.2 trillion deficit. That is real accounting.

Mr. KLECZKA. Okay, now—no, no, no, no. Is there not a balance in a trust fund that is not cash, that is promissory notes?

Mr. WALKER. That has value—it has legal significance.

Mr. KLECZKA. What is that amount?

Mr. WALKER. The amounts in the HI Trust Fund, let me see.

Mr. KLECZKA. No, I am looking for a comparison in 2013.

Mr. WALKER. Two hundred and eight billion dollars——

Mr. KLECZKA. Two hundred and eight billion dollars?

Mr. WALKER. In the HI Trust Fund——

Mr. KLECZKA. For what year?

Mr. WALKER. At the end of 2001, so at the end of 2002, $234.8 billion.

Mr. KLECZKA. All right, so that blue line would be much higher, and by the time you got to the red line, if you did an accurate accounting, that red would occur further out and would not be as

dramatic if you did a true accounting using the entire trust fund balance that is in promissory notes.

Mr. WALKER. Oh, we have that information. I have provided that before.

Mr. KLECZKA. Could you possibly provide it again, maybe in an updated form?

Mr. WALKER. I would be happy to.

[The information follows:]

Medicare's Hospital Insurance Trust Fund Balances 2002–25

Below are the Medicare trustees' 2003 intermediate estimates for all years in which the HI Trust Fund is shown to have a positive balance.

Estimates are provided in nominal and real (2003) dollars as of the end of calendar years.

CY	HI Trust Fund (EOY) (millions)	HI Trust Fund (EOY) (millions 2003$)
2002	$234,831	$240,467
2003	$258,537	$258,537
2004	$282,587	$275,991
2005	$310,944	$295,714
2006	$341,790	$315,828
2007	$375,185	$336,580
2008	$410,486	$357,535
2009	$446,563	$377,612
2010	$482,284	$395,964
2011	$517,390	$412,427
2012	$551,710	$426,954
2013	$583,578	$438,451
2014	$611,621	$446,146
2015	$634,426	$449,310
2016	$649,966	$446,897
2017	$656,658	$438,356
2018	$652,578	$422,928
2019	$635,688	$399,980
2020	$603,483	$368,674
2021	$553,018	$328,006
2022	$480,545	$276,716
2023	$382,258	$213,707
2024	$254,600	$138,189
2025	$93,987	$49,527

Source: GAO analysis and data from the Office of the Actuary, Centers for Medicare & Medicaid Services.

Mr. KLECZKA. So, at least we can honestly portray this. No one is talking cash-only, even though you might contend cash is king. I think you have to look at the total picture. If you are right, in year 2013 Congress shies away from making whole the trust fund and we don't want to cut spending or whatever to make the money whole, we will put up with a riot from those who put money into the fund, but nevertheless that is a congressional not a GAO decision.

Let me ask Dr. Holtz-Eakin a question about his chart. This is the one that is entitled Medicare Beneficiaries by Income Level and Drug Coverage.

Now, as I look at this chart, at all income levels, the blue line is pretty hefty, indicating that seniors have drug coverage. Did you do an analysis of what type of coverage we are talking about? Is this a moderate policy, is it a Cadillac plan, is this a couple of generics, is it a Medicare Choice-type thing—which naturally they are dropping the drug coverage. Is there an analysis of what the blue means? Is that decent coverage?

Dr. HOLTZ-EAKIN. Underneath those numbers are a wide variety of plans, in fact—some programs, which are employer——

Mr. KLECZKA. Medicare is in there also?

Dr. HOLTZ-EAKIN. This is coverage of any type. So, it is also employer-provided plans and Medigap policies. To the extent that they have coverage from any source, it is reflected in this——

Mr. KLECZKA. So, it goes from low to high. So, it is not really an indicator for the Committee or for the Congress that there is adequate coverage out there, or sufficient, or a decent benefit being provided to seniors? It is just who has anything?

Dr. HOLTZ-EAKIN. To the extent that we were trying to capture that, it is in the other graphs that show the degree to which beneficiaries would face out-of-pocket expenses versus covered expenses.

Mr. KLECZKA. Have either or both of you gentlemen looked at the President's drug plan that he submitted to the Congress?

Mr. WALKER. I have not analyzed the President's plan.

Dr. HOLTZ-EAKIN. The President provided insufficient evidence for CBO to do any real analysis of it, as we discussed in our analysis of the President's budget that we put out in March.

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY. The gentleman's time has expired.

Ms. Dunn.

Mr. STARK. I guess not.

Ms. DUNN. Thank you very much, Mr. Chairman. Thank you for being here gentlemen. Mr. Walker, I want to go to a point that Mr. McDermott touched on briefly. In your testimony you stated that Medicare pays overly generous rates. That is not, we feel in my State of Washington, necessarily close to the truth. You also mentioned that Medicare's payments are based on averages. I am very concerned about the variation in payments from one region to another. I am wondering if you come to us with any recommendations to create more equity in these payments. For example, do you have recommendations on the formula that is used to determine these payments?

Mr. WALKER. Not today, Ms. Dunn. Let me say that what is in my testimony talks about the fact that GAO has done work that

in some cases there are over-generous payments, not in all cases. We have also done work to show that there can be significant differences in what reimbursement rates are in different regions of the country, and also the reasonableness of what those reimbursements are between different types of providers. So, it is not a one-size-fits-all. I would be more than happy to follow up with you after the hearing, if you want.

Ms. DUNN. Yeah, I would appreciate that. It is a continuing problem in our State, where we believe we produce the best medical care available in the country, and yet we are having a hard time holding onto our doctors and keeping our hospital doors open because the reimbursements aren't there at the same rate that they are in many other States whose quality of care is not any better than ours.

Mr. Walker, let me ask you, too, about a GAO report that was released in January. It was on the role of the pharmaceutical benefits managers (PBM) in the Federal Employee Health Benefits program. I am wondering if you can summarize your findings in that report. Did beneficiaries, for example, have sufficient access, do you think, to retail pharmacies?

Mr. WALKER. I think the bottom line in that report is that PBMs are a tool that had been used, including by the Federal Employees Health Benefit Plan. It is a mechanism that the Congress may well want to consider in conjunction with providing a prescription drug benefit under Medicare. There are, however, some differences between how Medicare historically has been arranged—any willing provider, and so forth. There is an opportunity for cost savings here with regard to PBMs, but there are some adjustments that are going to need to be made if you're thinking about doing it under Medicare.

Ms. DUNN. Your comment on access to retail pharmacies?

Mr. WALKER. Most have a broad network. It can vary, but yes, there are access to retail pharmacies in some circumstances, yes.

Ms. DUNN. Thank you. Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman. Let me start off, if I could, by following up on Ms. Dunn's question. Your GAO report with regard to pharmacy benefit managers, it seems to me, gave us some good information with regard to the so-called brick-and-mortar or retail pharmacies. Many of them were quite concerned with the bill that was enacted—not enacted, but passed by this Committee and by the House of Representatives last year. Despite the fact that we did not allow direct-mail pharmacies to have a dominant position, still they were concerned that they might not be accessed by the Medicare prescription drug plan we put forward. So, I think to the extent you can provide us this new information in relation to this new legislation we are hoping to put together this year, it would be very helpful.

What I took from it was that in the experience of the Federal Employee Health Plan, that in fact there was access to retail pharmacies. Perhaps that is a good example for us to use and to try to allay some of those concerns, because all of us have them, particularly those of us who represent small towns where you have pharmacies that really provide more than just the prescription drug,

but also more health maintenance and preventive health for beneficiaries.

I would like to go back, though, if I could, to some of your earlier testimony. I apologize that you have to sit here and be told by some of our Committee Members that you are coming here to tell us how to get rid of Medicare. I feel just the opportunity about it. I think that is offensive to you, two professionals who, in the case of Mr. Walker, I know has spent a lot of time on this issue, and to our newest CBO Director.

I appreciate the fact that you are giving us what I view as straight talk. This is a very politically charged issue, as you have seen here this morning. Again, Mr. Walker knows that from working on it in the past. We need good data. I thought you were responsible in terms of how you presented the solvency issue because it is true that the lines do cross at 2013. It is true that then Congress has choices to make. You laid out those choices very specifically, including borrowing, including tax increases, including reducing benefits. These are tough choices that, in my view, Congress will have a very tough time making in 10 short years.

So, I thank you for bringing focus on that. We constantly hear that the year is 2027 or, now, 2026. So, I think, if anything, we need to bring more focus on the fact that we have a fiscal crisis that is more imminent. So, I appreciate that. I also appreciate the fact, again, you laid out what the options are at that point. So, I thank you for that.

I guess my question for you, Mr. Walker, would be, when you talk about "true accounting," you said in fact there would be a deficit—I believe you indicated that in response to Mr. Kleczka's question—at 2013. What did you mean by that?

Mr. WALKER. Well, what I meant by that was, if you were actually preparing a net worth statement and you were using accrual concepts, where you were trying to estimate what the discounted present value of what your future promises are and you look at what is the discounted present value of the revenue stream that you have to meet those promises, what is the gap, there is a $6.2 trillion gap for HI. I am just trying to provide the facts. Congress is elected, Congress has to make the judgments on what to do with the facts. Sometimes people don't like the facts, but they are nonetheless the facts.

Second, as you properly point out, and I appreciate it, I was a trustee in Medicare for 5 years. I care very deeply about Social Security and Medicare. I was a trustee of Social Security as well. We have to start dealing with the facts.

Mr. PORTMAN. Well, I appreciate that and I think, again, I view it just the opportunity. We are not talking about how to get rid of Medicare, we are talking about how to save Medicare. When you look at the demographic challenge we face with people living longer and with more and more baby boomers retiring—and I appreciate also the fact that your charts today indicate that, how much of it is due to the Medicare health care cost increases and that inflation is still, in my view, way too high to be sustained, but also just the aging population. My 98 year old grandmother, who is right now back in Cincinnati—if C–SPAN was on, she would probably be watching this, still very sharp—God bless her, but

there are more and more people in that situation. Eighty-year-olds are our fastest growing group. So, it is important that you lay that out, too. It is not just the fact that health care costs are increasing at unsustainable levels; it is this aging population.

Quickly to CBO: Your challenge is to help us determine whether some of these competition models really save money. I know that you have looked at some of these proposals. You indicated you hadn't looked at the President's proposal. My understanding is you have done some preliminary analysis of some of the proposals that they have for competition, and you have indicated they do not have significant savings. Is that not accurate?

Dr. HOLTZ-EAKIN. To date, we have had staff-level discussions on a variety of prototypes and thoughts. It is an overstatement to say that CBO has scored any specific proposal, the President's or otherwise.

Mr. PORTMAN. Well, we appreciate your focusing on that over the next several months, because it is going to be critical to us to figure out how to keep high quality of care and deal with this huge challenge. I know you will look at it creatively, because some of the existing models, I think, are inadequate. Maybe the Federal Employee Health Benefits Plan that GAO looked at is one model. Any models out there with regard to competition—choice, which is something that our seniors want—we certainly look forward to, because the existing model is not one that can be sustained. Therefore it is a failed model.

Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. I would like to begin by yielding such time as he may consume, but I hope it is not much, to Mr. Stark.

Mr. STARK. I just want to go back, Dr. Holtz-Eakin. You said that there wasn't adequate information on the President's plan for you to estimate it. Did I hear that in response to a question back one or two?

Dr. HOLTZ-EAKIN. In March, CBO conducted its traditional analysis of the President's budgetary proposals. The information we had at that time was that there was to be a Medicare prescription drug proposal that would cost $400 billion over 10 years. That was the extent of the information.

Mr. STARK. I did want to, and I heard Mr. Portman allude to this, too, that there was, according to the Wall Street Journal's weekly gossip sheet here, a very high-ranking government official who recently told some Members of the other body that the Medicare overhaul plan could add hundreds of billions of dollars in costs and that the Administration's cost-savings claims for its plan were disputed by the early data of a demonstration project. Small savings from encouraging seniors to opt for private plans would be offset by high administrative costs. I presume that—of course, that was just a shot in the dark by somebody who obviously didn't have adequate information on the President's plan.

Mr. MCCRERY. In court we would call that hearsay.

Mr. Pomeroy.

Mr. POMEROY. Thank you. First of all, I want to salute each of you for your work. In particular, David Walker and I have had

a chance to work together for years. I think we really have a winner with the comptroller general, a top-flight account, manager, and a health policy guru besides. So, you can certainly make a very important contribution going forward. I look forward to working with you in that regard.

I think your testimony on page 14 is very interesting. Well, your testimony is interesting throughout, Mr. Walker, but I really like on page 14, you talk about basically, making government fit the challenges of the future will require not only dealing with the drivers, such as entitlements for the elderly, but looking at the range of other government activities. Fundamental review of what the Federal Government does and how well it does it will be needed. This involves—and this is the most important part in my opinion, relative to what faces this Congress at this day: This involves looking at the base of all major spending and tax policies to assess their appropriateness, priority, affordability, and sustainability in the years ahead.

So, we had some discussion today about addressing prescription drugs in the context of an overall Medicare package, but it seems to me we ought to talk about Medicare much more in the context of the overall budget, especially the tax cuts that are the centerpiece of the Administration's, the House-passed plan.

Clearly a diminished revenue picture in light of the tax cuts proposed—first the growth package and follow along making the tax cuts permanent—will have what effect, Mr. Walker, on the ability of the Federal Government to meet these Medicare payments on a cash-flow basis as they come in in the next decade?

Mr. WALKER. It will reduce the revenues available. I try to be an equal opportunity fact-provider. That is generally to be consistent and to be transparent. We have done a simulation that shows what the effect would be if Congress decided not to extend the tax cuts. It would have an effect, but it is not enough of an effect to solve the problem. We are still going to need to do what you read in my testimony. The difference may be less, but there is still a significant gap in——

Mr. POMEROY. Absolutely. I am certainly not suggesting it is simply a matter of just not doing tax cuts, everything is rosy. I think we also have to come to grips with the fact that we are making a difficult situation a great deal worse, are quite possibly putting us in a framework where we really can't prudently commit the long-term commitment of a Medicare reform, including prescription drugs, if we would so significantly reduce the Federal revenue base.

Mr. WALKER. I think you need to consider it in the broader context. I think there are three levels—the overall fiscal challenge, health care, and Medicare. I believe you need to look at all of those.

Mr. POMEROY. Mr. Walker, because we operate in a 10-year budget window, but that really misses just around the corner what happens when the baby boomers retire and the costs hit, is there some analysis that you could do, or CBO could do, that would somehow help us as we look at revenue issues now what that means in terms of impact next decade relative to meeting these existing commitments, the Social Security and Medicare?

Mr. WALKER. Well, I think one of the graphics that I showed was the long-range budget simulation gives you a feel for that. One

of the things I believe Congress needs to consider before it enacts legislation is that you need to consider the discounted present value cost of both spending and tax sides before you make the decisions. You need to consider what the bottom-line impact is. I believe that is very important, and should be consistent on both sides.

I should also say one last thing. I think this Committee, Ways and Means, also needs to look very hard at existing tax incentives for health care. I would respectfully suggest that they are making many consumers less aware of the cost of health care and maybe fueling health care cost increases.

Mr. MCCRERY. Thank the gentleman for that astute comment. Mr. Hulshof.

Mr. HULSHOF. Thanks, Mr. Chairman. Those that will examine this record will examine the entire record, I feel compelled to respond to some of those who commented earlier, specifically to the Ranking Member and the gentleman from Washington State. It seems interesting, Mr. Chairman, that when the full Committee meets to consider a Chairman's mark, we hear protestations about the fact we have not held hearings. Today we are holding hearings, and the objection from the other side, the lament, is that we don't have a bill to consider. Which reminds me of an old law school axiom: When the facts are against you, you argue the law; when the law is against you, you argue the facts; and when the facts and the law are against you, you pound the podium.

I would also say to the gentleman from North by-gosh Dakota, my friend—and even to Mr. Levin of Michigan earlier—who were talking about 10-year projection numbers. Mr. Levin specifically decried "the use of figures for particular political interests." I think I jotted his comment down adequately. As recently as 1997, when this full Committee considered the Balanced Budget Act, there was never a hint or argument about a 10-year projection. There were 5-year numbers, because the House operates under 5-year numbers. It is only since then that not only do we talk about 10-year implications, but now 15 and 20 and 30 year implications about tax cuts and the like. So, I think I just wanted to insert that editorial comment of my own and then get to a question.

Dr. Holtz-Eakin, I am also privileged to serve on the Committee on the Budget along with this Committee. As we debated the Medicare proposal, prescription drug and modernization—and I do include those worlds equally, I would say that I think the CBO estimate alone may not fully inform us of the consequences of various prescription drug proposals. Let me ask your comments on that.

We could have a $400 billion proposal that might lead to lower costs for purchasing prescription drugs, it could lead to more marketplace competition, it could lead to more innovative drugs being introduced into the marketplace. Or we could have a $400 billion proposal that could lead to no additional innovation, no price stabilization. So, really, what we choose to do—we can have this $400 billion new proposal, and yet depending on which direction we go, and each of you talked about innovations and incentives and consequences of those incentives, how critical is it from an economist's perspective that any Medicare modernization bill or prescription drug bill encourage competition among private firms, increase ac-

cess by new firms and encourage innovation for new drugs and technologies?

Dr. HOLTZ-EAKIN. Speaking as an economist, it may be the case that, consistent with the charts we showed you, this Nation chooses to spend an increasing fraction of its wealth on medical care broadly defined. However, for those dollars to be used wisely, one must give participants the incentives and opportunity to channel those dollars to those particular drugs or therapies that are the ones that they value the most highly, and that is the traditional economic route to getting high value per dollar.

Mr. HULSHOF. To go even—and to look at our current Medicare program, the current fee-for-service program is an any willing provider program. If we perpetuate that structure in a prescription drug program and we put aside the use of formularies or select contracting with pharmacies, what impact would that have on our ability to control costs? Maybe another way to ask you the question is, what incentives are there to control costs if the government holds 100 percent of the risk?

Dr. HOLTZ-EAKIN. I think a concrete way to answer the question is to look back at previous CBO analyses of prescription drug proposals in previous Congresses and look at those situations in which there were perceived to be cost-containment incentives and opportunities on the part of providers—whether they were at risk for the insurance losses, whether they had tools available to choose low-priced drugs, whether there were price signals sent to beneficiaries to choose among providers on the basis of costs. All of those things figured into CBO's cost estimates.

Mr. HULSHOF. I appreciate both of you gentlemen, especially with the charts, which I think are quite telling. I have back in Missouri a fairly substantial town meeting coming up, and would ask the opportunity to use these charts that you have shown to us today to help explain some of the challenges that we have because I think they are quite telling.

Mr. MCCRERY. Mr. English.

Mr. ENGLISH. Mr. Chairman, will yield my time to Mr. Portman.

Mr. PORTMAN. Well, thank you, Mr. English. I didn't know I would have this opportunity, but let me go back to some of the earlier questions and some of the legitimate concerns that were raised on proposals that might be before this Committee and just make what is maybe an obvious point.

Medicare and Social Security, as well as some other major controversial and, as I said earlier, politically controversial issues should be handled on a bipartisan basis, really have to be to be successful. I think it was President Jefferson who said a big issue should be more of a point of consensus rather than a bare minority or a bare majority.

One of my concerns is that, as we criticize the various proposals, we are not hearing alternatives from the other side of the aisle as to what they would do with regard to these I think now well-defined solvency issues.

So, I would just urge my colleagues on the other side give us your best ideas. We could always come up with a Medicare prescription drug coverage plan that costs $1 trillion a year or $1 tril-

lion over the 10-year period, and Mrs. Johnson talked about that, that would be politically popular in certain circles. It would not be the responsible thing to do.

We, instead, are trying to both provide this needed coverage which, in the modern day, must be there, but also modernize the program itself so that it can be sustained over time. So, I would just make the obvious point that, while it is easy to criticize and to poke holes in the various proposals that are going to come up, the responsible thing would be to offer alternative proposals.

In the area of Social Security, we have the 75 year solvency standard criteria. I would suggest here the criteria might be some of the challenges you have faced us with today, including the crossing of the line, as I said earlier, between the revenue coming in, and the benefits being paid out in 2013 or even pushing it back to 2026, coming up with some way to fund that interim period, but we need to have some standards, and I wonder if the two of you could perhaps comment on that, putting you on the spot here of, maybe Dr. Holtz-Eakin, you could go first. What should the standards be for Medicare modernization and prescription drug proposals that we could compare, instead of apples to oranges, apples to apples? What would you say would be the appropriate criteria?

Dr. HOLTZ-EAKIN. In that area, I guess I would offer two thoughts. The first is that we presented our analysis of the long-run trajectory for Medicare looking at the current program relative to the size of the economy, and I think that is a useful baseline to use because it makes the point that in the end, the economy is the ultimate source of all of the resources to be devoted to health care and other needs. The second point is that the financing mechanisms that the Congress might choose to meet those needs are at their disposal. It could be debt financing; it could be tax financing or we could choose to lower the trajectory for Medicare outlays.

So, I think that the right standard is to compare programs relative to the economy—especially over the long term—when making decisions in the present that have long-term consequences.

With respect to comparing proposals on an apples-to-apples basis, the traditional way to do so is to attempt to make sure that proposals have the same value per dollar, and I can offer you only small comfort in that regard because whether a proposal is "worth it" in the eyes of the Congress will ultimately be your decision. We can provide you with the dollars and allow you to compare the dollars on an equal basis. Whether their proposals are worth it or not is a larger question.

Mr. PORTMAN. Mr. Walker.

Mr. WALKER. Mr. Portman, the GAO did some work in conjunction with Social Security, where we came up with a list of questions that we recommended that the Congress consider in deliberating any Social Security reform proposal. We are in the process of doing the same thing for health care, and I expect that that will be done within the next month. I would respectfully suggest that this Committee and the Congress as a whole may want to consider these questions in analyzing various proposals. We can be helpful in that regard, but in the final analysis, you are the elected officials. You have to make the judgments as to what is appropriate to do.

I will agree with Doug to say that I think looking at things as a percentage of the economy, a percentage of the budget in different ways, moving beyond trust funds, which are really not trust funds in Webster's Dictionary. They are accounting devices. That is what they are, nothing more, nothing less.

Mr. PORTMAN. I think you have made that point clearly today early in your testimony, and I would just respectfully say that if you look at, as a percentage of our economy or as a percentage of our budget, what mandatory spending is, in general, of course, we have seen dramatic increases, and the projections are for even greater increases, I am not sure that that criteria is one that we would adhere to as Members.

So, anything you can give us, in terms of those questions or even in terms of just establishing some criteria to be able to compare the various proposals on a fiscal basis would be very helpful.

Mr. WALKER. Ours cover much more than cost. They cover access administration, quality and other issues.

Mr. PORTMAN. Right, quality issues.

Mr. WALKER. It is a much more balanced approach. It is not just focused on cost because in the end you need to consider more than just cost.

Mr. PORTMAN. Right. Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman, and thank you to the two of you for your testimony and your time.

I would like to, if I can actually for 1 second, refer back to the GAO chart. I want to make sure I am clear on something. In terms of the out-years, in 2050, the largest component that you identified there is net interest, and I am assuming that means the interest we pay on the national debt.

Mr. WALKER. That is correct.

Mr. BECERRA. It seems that it is not much smaller than the combined costs of Medicare, Medicaid and Social Security come 2050. I know that the Congressman from North Dakota was asking some questions with regards to this, and I would like to follow up on what Mr. Pomeroy was asking.

If we believe that the size of the debt, which will require interest payments larger than any other of these other programs and almost as large as three of our greatest programs combined, would it not seem that we would want to be making decisions today that help us decrease the size of the national debt, and therefore decrease not just for this year, but in the out-years the amount of interest payments we will be making on that debt?

Mr. WALKER. I think a different way of saying it is deficits do matter. It is important. Obviously, the amount of the deficit, the nature of the deficit, the timing of the deficit—is it a time of war or recession—should be considered, but ultimately you need to get back into balance over the long term.

Mr. BECERRA. If I am correct, the President's budget proposal would have us with a deficit for each of the 10 years, in the succeeding 10 years of his plan, and thereby increasing the size of the national debt. If we were to eliminate his proposals to, one, permanently extend the 2001 tax cut, which is factored into this chart, but also eliminate the other proposed tax cut that he has of some

$700 billion over 10 years, principally with regards to dividend repeal, tax repeal, would we see that very dark blue and large box under the year 2050 that represents net interest also come down?

Mr. WALKER. That is correct. We have done that. It would come down, and it would come down significantly. It would still be significantly higher than it is today, and you would still have a significant long-range problem to deal with.

Mr. BECERRA. So, even if we were to cut all of the President's tax cuts, we still have a lot of work to do because there is a lot more that goes into making the national debt and the annual deficits that we are facing than just the tax cut. I think most folks understand that, but we have got to, at some point as you said, start to bring this budget back into balance.

Certainly, if we are going to see a net interest payment that large, representing that high a percentage of our GDP, it would seem that we would want to start now to move toward that road of fiscal responsibility.

Let me ask another question. Dr. Holtz-Eakin, I think you mentioned this in earlier testimony that about 70 percent of Medicare's growth is due to excess health care cost growth which, as I think you have mentioned in the past, is not unique to Medicare. The private sector has faced this as well.

If the private sector isn't doing much better or any better, and some people would say it is doing worse, but if it is not doing any better than Medicare at controlling the growth and its costs, and in fact I think most people would agree that Medicare has done a better job than the private insurers in curtailing costs, how do we expect a program that would turn over, as the President proposes in his plan, Medicare or prescription drug benefits to private plans, in essence, privatizing senior's health care, at least for prescription drugs, how would that help us reduce costs under Medicare?

Dr. HOLTZ-EAKIN. There are really two answers to your questions. The first is that if one looks historically, if one goes back and looks at growth of costs for private-sector payers and growth of costs under Medicare, while on a year-to-year basis Medicare may be above or below the private sector, but on balance, they tend to end up in roughly the same place.

Mr. BECERRA. Pretty close.

Dr. HOLTZ-EAKIN. So, I wouldn't characterize one as being faster or slower than the other in any sustained way.

Then with respect to any proposals on prescription drugs and their cost-containment features, I would refer back to the things that I have mentioned already in my testimony.

The degree to which there will be cost containment depends on—in many, many detailed ways—on the particulars of the proposal and the degree to which there are features such as providers who are at risk and have incentives to control their costs, beneficiaries who are responsive to price signals and face some incentive to minimize costs, and a wide variety of other features of the proposal. As a blanket statement, it is impossible to characterize how that comes out.

Mr. BECERRA. Mr. Chairman, I know my time has expired, if I could ask one last quick question. Do either of you believe that we could try to maintain the cost in a private-sector plan, when it

comes to administrative costs at least, or those costs that are ancillary to the actual provision of health care. So, in the case of Medicare, we are talking about administrative costs, and in the case of a private plan, the administrative costs would probably be complemented with marketing costs and profit that would have to be added for the private plan.

Is there any way that we could try to corral those costs for any private plan so that they are about what Medicare currently pays in administrative costs, which I understand is about 3 percent?

Dr. HOLTZ-EAKIN. The evidence is, thus far, for existing private plans versus Medicare, is that administrative costs are higher for HMOs and Preferred Provider Organizations (PPOs) that we see. Going forward, how that would play out remains to be seen.

Mr. MCCRERY. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman, and let me thank both of our witnesses. I am not sure we are asking the right question. So, let me see if I can at least get your view on this. We are looking at this to try to save the Federal Government money in the Medicare system, which I understand are the growth of the cost to the Federal taxpayer, but it seems to me that we are talking about health care costs increasing. To the extent that we put in these so-called reforms or deal with the changes as to what the Federal Government will pay, we may very well be adding to the burden of the individual and not really dealing with reducing health care costs or the growth of health care costs in the country.

I am looking at MEDPAC's study, which indicates today that for all beneficiaries, including institutionalized, and those in Medicare+Choice (M+C), Medicare covers 52 percent of the total cost. So, a large part is already being paid for by the beneficiaries directly and not by the Federal taxpayer.

Then according to MEDPAC analysis of Medicare Current Beneficiary Survey (MCBS), growth in out-of-pocket costs for fee-for-service beneficiaries living in the community has outpaced growth and their income. The largest source of out-of-pocket growth has been for non-covered services.

I could also go into those that are in some form of a managed care plan. The coverage for non-covered service has been shrinking. So, it seems to me that when you put that all together, we run a real danger of putting a lot of pressure here to reduce the Federal taxpayer share, but in fact will be placing more burdens on the individual. I would just appreciate your comments. Are we looking at this the wrong way?

Mr. WALKER. Well, first, I think you have to keep in mind that that 52 percent number, as I understand it, just talks about Medicare, that you have Medigap paying costs——

Mr. CARDIN. That, in many cases, is 100 percent of the costs——

Mr. WALKER. No, it is not 100 percent, but you have got to consider that Medigap is paying costs, and employers are paying costs with regard to retiree health care.

Mr. CARDIN. On every one of those cases, the individual beneficiary is paying for that. It may be paying for it in salary compensation, may be paying for it in full cost of the Medigap pre-

miums. They might have some help through their prior employment arrangement——

Mr. WALKER. Right.

Mr. CARDIN. Low-income people of course get some help. As far as the Medicare system, it is not paying it.

Mr. WALKER. I understand, but the other thing you have to keep in mind with those numbers is that they also include nursing home costs, and one could debate whether that is solely a health care cost. I don't believe that is solely a health care cost. Some of the services that are provided are not health-care related services when you are in a nursing home; housing or basic food, subsistence——

Mr. CARDIN. I think that is a good point on the 52 percent, but it still points out that if we are just shifting who is paying the cost here, the seniors, as a class, are already burdened in their out-of-pocket costs as it affects their standard of living that they have to pay for health care.

Mr. WALKER. Mr. Cardin, you might not have been here when I mentioned that GAO is preparing a briefing report that I think would be helpful to this Committee and the Congress on what has happened in health care in the last number of years. I think you will be surprised to see that in the aggregate, the individual's portion of health care costs has gone down dramatically in the last 40 years, the percentage being paid by individuals, in the aggregate, of overall health care costs, but that varies by——

Mr. CARDIN. Does that include seniors? Are you saying seniors' costs have gone down?

Mr. WALKER. It varies by age group, but in the aggregate, if you look at who was paying health care costs back years ago——

Mr. CARDIN. Well, I would be curious to see how that breaks down by seniors.

Mr. WALKER. Sure.

Mr. CARDIN. That is what we are talking about today.

Mr. WALKER. I understand that. No, I understand that.

Mrs. JOHNSON OF CONNECTICUT. Will the gentleman yield a minute?

Mr. CARDIN. I would be glad to.

Mrs. JOHNSON OF CONNECTICUT. I think the point of your question was does people taking first-dollar coverage have an impact on utilization or is it just shifting who pays?

Mr. CARDIN. Well, I am not sure about that because the utilization issue is a separate issue, and there has been no demonstration that we will get, there are over-utilizations adding to the cost here.

Let me ask one more question, if I might, because my time is running short. The Chairman mentioned in the beginning $400 billion is in the budget for a Medicare prescription drug plan. Can you tell us just very quickly is that anywhere near enough money, in the ballpark, to cover a prescription drug plan which is typical for those under 65 that they have in commercial insurance, such as what Members of Congress would have in the Federal Employees Health Benefit plans? Would $400 billion come close to covering those types of costs? Just so we have some yardstick here as to the moneys that are being put on the table.

Dr. HOLTZ-EAKIN. Mr. Congressman, I guess if I could ask a little clarification. When you say "those costs," which costs do you refer to? Our baseline has about——

Mr. CARDIN. If we were going to provide the benefits of a typical plan provided those under 65, such as the Federal Employees Health Benefit Plan prescription drug coverage, how much money would it cost over 10 years?

Dr. HOLTZ-EAKIN. The reason I asked is that if you go back to the charts we pointed out, out of a baseline of, say, $1.8 trillion, roughly three-eighths, or about $600 billion is currently out-of-pocket. If those costs are what you are trying to cover, then $400 billion is two-thirds of that.

If you are trying to construct a prescription benefit plan that would replace current sources of insurance coverage for prescription drugs, then the number would be much larger. So, it really depends upon the objective that you have in mind.

Mr. CARDIN. In any case, it would be much larger than $400 billion. If we had no deductibles and 25 percent co-pays, I am just looking at the Blue Cross Standard Option Plan, which has a 25 percent co-insurance, no gaps in coverage, stop loss for all medical benefits, that would cost well in excess of $400 billion, I take it.

Dr. HOLTZ-EAKIN. Clearly.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Stark, you have a quick follow-up?

Mr. STARK. I just wanted to comment on Dr. Holtz-Eakin's statement previously that the difference in increasing costs between Medicare and private plans. I am not sure that that is quite correct.

Dr. Moon's study recently indicated that over the previous 30 years, health care cost increases for private insurance was 41 percent higher than Medicare. Now, for the first 15 years, approximately, they were almost identical, but that was prior to our putting any real cost controls into Medicare, and since we have put cost controls into Medicare, the rate of increase of the private insurers has been far higher in the last part of that 30-year period in every year and to a significant degree, and I would not want the record to suggest that private plans come anywhere close to the Medicare system insofar as controlling increase in costs.

Dr. HOLTZ-EAKIN. I am not familiar with the details of that study. We would appreciate getting a copy.

Mr. STARK. Yes, you certainly should be.

Dr. HOLTZ-EAKIN. I would caution that, in making these comparisons, making sure that you compare apples with apples is usually the hard part.

Mr. STARK. She adjusted this to age and, indeed, this was adjusted to compare exactly because there are two different populations, and this was thus adjusted.

Mr. MCCRERY. Well, I appreciate the gentleman bringing that to our attention. I wonder if she included, though, things like compliance costs that the Medicare program imposes on the private sector that they have to comply with, and that is probably not accounted for in her numbers or certainly not in the 3-percent figure that we hear all the time, as far as the administrative costs of the Medicare system. I wonder if our witnesses would like to comment

on whether the Medicare compliance costs are figured in when we talk about administrative costs.

Dr. HOLTZ-EAKIN. With regard to the comparisons that are on the table, the compliance costs I can get back to—I do not know the details there. The CBO looked at the study, and we have a different interpretation of the historical data. In particular, the apples-to-apples comparison requires comparable benefits. I would be happy to work with the Congressman in making that comparison as clean as possible.

Mr. MCCRERY. One question to Dr. Holtz-Eakin. On the question of whether we should write into law the premium dollar amount for the pharmaceutical plans, do you believe that a prescription drug plan, which does a very good job at negotiating with pharmaceutical manufacturers and others in the distribution chain, should have the same premium as a plan that doesn't do a great job in those negotiations?

Dr. HOLTZ-EAKIN. In looking at and evaluating such a plan, the degree to which plans can offer different prices sends a clear signal to beneficiaries to pursue lower-cost plans if those plans also meet the other parts of their desires. To the extent that mechanism is available, we will facilitate cost containment. On the other hand, it also presents the possibility that different beneficiaries will face different prices if they reside in different regions. Those are the elements that we considered in looking at those plans.

Mr. MCCRERY. If we put the dollar amount in law, the incentive for a plan to do a better job would go away, wouldn't it?

Dr. HOLTZ-EAKIN. That is true.

Mr. MCCRERY. Thank you. Thank you, gentlemen, very much for your testimony and your responses to our questions. I call the next panel.

Ms. TUBBS JONES. Mr. Chairman——

Mr. MCCRERY. If you wish, you may inquire, although you missed the entire hearing, you may——

Ms. TUBBS JONES. Mr. Chairman, for the record, I did not miss the entire hearing. I had been here before, but I had to leave for another meeting.

Mr. MCCRERY. Okay, you may inquire.

Ms. TUBBS JONES. Just so the record is clear. I don't want to make a big deal, but I did hear their testimony.

Mr. MCCRERY. You did?

Ms. TUBBS JONES. I did hear their testimony.

Mr. MCCRERY. According to your staff, not here at the beginning.

Ms. TUBBS JONES. Well, take my word, not my staff, okay?

Mr. MCCRERY. You may inquire.

Ms. TUBBS JONES. Thank you, Mr. Chairman. Mr. Walker, earlier in your testimony today, you were talking about percentages with regard to GDP. Do you recall that testimony?

Mr. WALKER. Yes, I do.

Ms. TUBBS JONES. My question goes to, and your responsibility as the U.S. Comptroller General, you are looking at all costs in the government, not just particularly in the health care, as we are talking about today.

Mr. WALKER. That is correct, among other things.

Ms. TUBBS JONES. Among other things, yes.

What percentage of the GDP are the dollars that we have expended so far in the deployment of the military, the expenses in terms of machinery, and so forth, and the war in Iraq? What percentage of the GDP is that?

Mr. WALKER. Well, just back of the envelope, the current request is I think $80 billion, if I am not mistaken.

Ms. TUBBS JONES. Correct.

Mr. WALKER. Sixty-billion dollars for the U.S. Department of Defense (DOD), but I think——

Ms. TUBBS JONES. It is $80 billion, the pack. The supplemental was $80——

Mr. WALKER. The DOD was $60——

Ms. TUBBS JONES. Right.

Mr. WALKER. So, you take $60 billion, and the overall economy is, about $11 trillion. So, less than 1 percent.

Ms. TUBBS JONES. Less than 1 percent. What percent of the GDP would the proposed—there is a proposal by the Democrats to fund a prescription drug benefit for senior citizens in conjunction with the existing Medicare program. Do you have any idea what percentage of the GDP that proposal is?

Mr. WALKER. I am not familiar with any proposal that is on the table right now for a prescription drug benefit, but if you mean last year's, last year's was what, $900 billion, roughly, over 10 years?

I don't recall how much it is per year, but if you assume that it was about the same per year——

Ms. TUBBS JONES. Assume $900 billion.

Mr. WALKER. Ninety-billion dollars, it would be less than 1 percent of GDP.

Mr. STARK. Would the gentle-lady yield for just a moment?

Ms. TUBBS JONES. Absolutely.

Mr. STARK. The $80 billion for the Defense was 6 months, and ours was for 12 months—our drug benefit—so I would suspect that you would have to——

Mr. WALKER. We don't know what the cost is going to be. Frankly, I have got a son who is a company commander with the Marine Corps in Iraq right now. So, we don't know how long they are going to be there, and we don't know what the cost is going to be.

Ms. TUBBS JONES. You know what, my heart goes out to you having a son over there. I have lost two of my constituents, and the point is not to argue our patriotism. What I wanted to bring to the attention of the Committee and to those who are listening is the fact that previously Secretary Snow said it doesn't matter what the cost of the war, it is minor in terms of the GDP.

If you assume his statement is correct, and you assume that the 1 percent of GDP is what you are suggesting the Democratic plan, though you are not familiar with it, would cost, that is minor, compared to the GDP, to pay for the cost of a prescription drug benefit for all seniors. Would you agree with that, sir?

Mr. WALKER. I think you are comparing apples and oranges, though, with all due respects.

Ms. TUBBS JONES. What are the apples from your perspective?

Mr. WALKER. Let me tell you why I say that. You may or may not agree.

Ms. TUBBS JONES. We have a short amount of time, just so you know that.

Mr. WALKER. I understand that. The cost of the war is not going to be forever. We are not going to be in Iraq forever. However, the cost of a prescription drug benefit, unless Congress decides to rescind that benefit, after it passes, will be forever.

Ms. TUBBS JONES. I understand the forever language, but the people that would be covered by the prescription drug benefit for as long as they live. They have been forever, most of them paying into our—are paying taxes, and they are forever our people. They are our mothers, our fathers, our sisters and brothers, and we are going to be forever grateful to them for the work that they have done to allow us to be sitting where they are sitting today. Fair?

Mr. WALKER. I would agree with that.

Ms. TUBBS JONES. Thank you. Dr. Holtz-Eakin, I am sorry. I would have asked you a question, but I can't. I have run out of time. I am on yellow. At another juncture, I hope to be able to engage with you and ask you a few questions, and I yield back my time, Mr. Chairman, and I thank you for the opportunity to ask questions.

Mr. MCCRERY. You are quite welcome. Thank you very much, gentlemen, for your testimony and your responses, and now I would like to call up our next panel; three Ph.D.'s, Dr. Stuart, Dr. Pauly and Dr. Reinhardt.

We have testifying on our next panel—I am going to let Mr. Cardin introduce his constituent. Before I do that, I will say the other two witnesses are Dr. Uwe Reinhardt, who is a professor of Economics and Public Affairs, the Department of Economics and Woodrow Wilson School of Public and International Affairs at Princeton University; Dr. Mark Pauly, professor, Health Care Systems, the Wharton School, University of Pennsylvania.

Mr. Cardin, if you would honor us with your——

Mr. CARDIN. We are very pleased to have Dr. Bruce Stuart with us today from the University of Maryland School of Pharmacy, the Peter Lamy Center on Drug Therapy and Aging. Dr. Stuart has been a tremendous help for us locally, as well as nationally, on these issues and it is a pleasure to have him here for the Committee on Ways and Means.

Mr. MCCRERY. Thank you, Mr. Cardin, and thank all of you, gentlemen, for appearing today. Your written testimony will be submitted for the record. If you could, in about 5 minutes, summarize your testimony, we would appreciate it. Dr. Stuart, we will start with you.

[Questions submitted to Mr. Walker from Mr. Houghton, and his responses follow:]

Question: I understand that historically when Congress has added a new benefit or when CMS makes a national coverage determination, all other insurance becomes secondary to Medicare regardless of whether it is offered through supplemental insurance, a private plan, or Medicaid. Is this correct? Is this coordinated sufficiently under current law and regulations so that all people, regardless of their coverage, understand the rules?

Response: Whether Medicare would be the primary or secondary payer depends on the type of other coverage the beneficiary has. In general, Medicare is the primary payer for covered services when a Medicare beneficiary has any of the following sources of supplemental coverage:

a. Medigap insurance, which is designed to supplement Medicare by paying certain cost-sharing requirements or non-covered services (42 U.S.C. § 1395ss),
b. Medicaid, which statutorily is always the insurer of last resort (42 U.S.C. § 1902(a)(25)), or
c. employer-sponsored health coverage when the beneficiary and spouse are no longer employed.

In general, Medicare is the secondary payer for covered services when a Medicare beneficiary is:

a. working and has employer-sponsored group health coverage (42 U.S.C. § 1395y(b)),
b. not working but is covered by a working spouse's employer group health plan,
c. treated for a condition or an injury where a third party may be liable for medical services provided, or
d. afflicted with end-stage renal disease during the 30-month coordination period.

The liability for Medicare or other payers to pay for these services depends on coverage determinations by CMS and the plans. One would have to look to the terms of the other plan's coverage to determine how that plan's coverage will be affected by a Medicare decision. For example, if Medicare began covering a health care service for which it would be the primary payer, a beneficiary's other plan would either provide secondary coverage or no coverage depending on the terms of that plan. Alternatively, if an employer's group health insurance is the primary payer but does not pay in full for certain Medicare-covered services, Medicare may provide secondary coverage; however, if the group plan denies payment for these services, Medicare may pay as primary payer.

Accurately determining whether Medicare is the primary or the secondary payer and effectively coordinating these benefits requires that the CMS have timely information on any other sources of health coverage that a beneficiary may have both at the time of initial eligibility for Medicare and when any changes occur. CMS provides information to beneficiaries and providers about coordination of benefits, the need to provide accurate insurance information, and Medicare's role as primary or secondary payer on its Web site (http://www.cms.hhs.gov/medicare/cob/) and through other means.

There is no question that this issue is complex and making it understandable to everyone is challenging. Fortunately, the number of instances where confusion will arise is small relative to the numbers of Medicare beneficiaries and services. Medicare covers a broad variety of services, including inpatient hospital care, skilled nursing facility care, certain home health and hospice care, physician and outpatient services, diagnostic services, outpatient physical and occupational therapy, ambulance services, and other medical services and supplies. Coverage policies impose some limitations, but such policies are important as they seek to assure that Medicare only pays for necessary valued services.

Question: If we were to enact a drug benefit that allows employers the option to continue retiree coverage and tap into the Medicare drug subsidy, do you think it will be confusing for Medicare beneficiaries, especially if the "Medicare plan(s)" differs from the employer-sponsored plan? For example, a beneficiary may not know who pays each time they go to the pharmacy (whether it is the Federal Government, private insurer or paid out of pocket). Obviously we need a structure that retirees understand, can you make recommendations on how to avoid confusion in layering a Medicare benefit with employer sponsored coverage?

Response: I agree that it will be very important to provide Medicare beneficiaries with clear and comprehensive information about any choices they would have under a proposed Medicare drug benefit. As I stressed in my statement, if multiple private entities were selected to administer drug benefits, a means to ensure that beneficiaries receive comprehensive user-friendly information about policy and benefit differences among competing entities would be necessary. Similarly, such comprehensive information will be necessary to help beneficiaries determine how any new Medicare covered drugs would coordinate with existing sources of drug coverage, such as employer-sponsored group health plans and Medigap, as well as the effect on beneficiaries out-of-pocket payments. Beneficiaries will need such informa-

tion to make informed decisions regarding whether to maintain or opt out of current supplemental coverage—an especially important decision as the availability of employer-sponsored retiree health benefits has generally declined over the last decade and many employer-sponsored group health plans have increased cost-sharing requirements.

One option that you may consider to reduce confusion for Medicare beneficiaries maintaining employer coverage is to provide a subsidy for premiums of a private plan offering a drug benefit rather than having dual coverage through both a private plan and Medicare. Then each beneficiary with drug coverage would only be affected by one set of coverage and copayment rules. This would also avoid the situation we have now where supplementary insurance, like Medigap, ends up making beneficiaries less sensitive to the costs of services and contributes to the fiscal challenges the Medicare program faces today.

[Questions submitted from Mr. Levin, Mrs. Johnson, and Mr. Ramstad to Mr. Holtz-Eakin and his responses follow:]

Levin Question: Please provide a historical series of CBO's projections for Medicare spending over the last six or seven years.

Response: Table 1 shows the Congressional Budget Office's (CBO's) projections of Medicare spending and actual Medicare spending for the years 1995 to 2002 (with projections extending into future years as applicable). The projections of "baseline" spending shown there for each 10-year period-which were made in January or March of the previous year-reflect current law governing Medicare at that time. Actual spending will differ from projections for a variety of reasons, including subsequent changes in legislation or in the underlying economy. For example, the projections of Medicare spending made prior to the passage of the Balanced Budget Act of 1997 were substantially higher than the projections made after that point.

Johnson Question: As a supplement to the chart on long-term Medicare spending included in your testimony, please show the effect of adding prescription drug benefits at varying levels (with 10-year costs of $500 billion to $1 trillion).

Response: Table 2 shows how Medicare spending as a share of gross domestic product (GDP) would vary depending on the size of the10-year drug benefit that was enacted. As the table indicates, Medicare spending in 2075 could range from 9.2 percent of GDP under current law to 12.5 percent if a drug benefit costing $1 trillion over 10 years was enacted today. The estimates incorporate the assumption that drug spending outside of the 10-year budget window will grow with the rest of Medicare (as a share of GDP). That assumption is preliminary and subject to review, and considerable uncertainty surrounds any projection made over such a long period.

Ramstad Question: Please provide estimates of GDP and Medicare spending in 2075 in nominal dollars.

Response: Nominal GDP in 2075 will be $293 trillion, and Medicare transfers will total $27 trillion, according to CBO's preliminary projections. Because such figures are difficult to compare with current levels of spending and economic output, the estimated share of GDP devoted to Medicare spending-in 2075, 9.2 percent-can be a more useful metric.

Table 1.—Medicare Baseline Actuals and Projections, 1995 to 2013 (Actuals shown in bold)

Fiscal Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
March 1996										
Benefits	176.9	195.8	215.3	236.2	257.2	279.3	303.1	328.4	356.9	388.9
Premiums	20.2	20.0	20.6	22.6	24.0	25.1	26.2	27.4	28.6	30.0
Net Benefits	156.7	175.8	194.7	213.6	233.2	254.2	276.8	301.0	328.3	358.9
Jan 1997										
Benefits		191.0	207.9	226.0	247.1	271.8	284.4	312.4	337.9	366.8
Premiums		20.0	20.2	21.4	22.4	23.4	24.5	25.6	26.7	28.0
Net Benefits		171.0	187.7	204.6	224.6	248.3	259.9	286.8	311.2	338.8

Table 1.—Medicare Baseline Actuals and Projections, 1995 to 2013 (Actuals shown in bold)—Continued

Fiscal Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Jan 1998										
Benefits			207.0	216.6	229.6	242.2	266.0	275.5	304.1	328.9
Premiums			20.4	20.9	22.8	25.2	28.0	31.1	34.6	38.5
Net Benefits			186.6	195.8	206.8	217.0	238.1	244.5	269.5	290.5
March 1999										
Benefits				210.1	212.1	227.6	243.1	253.2	277.1	298.5
Premiums				20.8	21.5	23.2	25.4	27.7	30.6	34.1
Net Benefits				189.4	190.6	204.4	217.7	225.5	246.5	264.4
March 2000										
Benefits					208.3	216.9	234.8	242.4	262.9	282.1
Premiums					21.6	21.8	23.3	25.4	28.1	31.1
Net Benefits					186.7	195.1	211.5	217.0	234.8	251.0
March 2001										
Benefits						214.9	237.0	251.4	268.5	288.0
Premiums						21.9	23.6	26.9	30.0	33.3
Net Benefits						193.0	213.4	224.5	238.5	254.7
March 2002										
Benefits							236.5	246.9	259.4	272.7
Premiums							23.7	25.9	27.8	29.7
Net Benefits							212.7	221.0	231.6	243.1
March 2003										
Benefits								252.2	271.3	285.7
Premiums								26.0	28.3	31.6
Net Benefits								226.2	243.1	254.1

Table 1.—Medicare Baseline Actuals and Projections, 1995 to 2013 (Continued)

Fiscal Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
March 1996									
Benefits	424.0	463.0							
Premiums	31.1	32.1							
Net Benefits	393.0	430.9							
Jan 1997									
Benefits	408.4	436.2	462.6						
Premiums	29.3	30.7	32.3						
Net Benefits	379.1	405.5	430.4						

Table 1.—Medicare Baseline Actuals and Projections, 1995 to 2013 (Continued)—Continued

Fiscal Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Jan 1998									
Benefits	365.6	375.3	415.4	447.0					
Premiums	42.4	46.4	50.6	55.1					
Net Benefits	323.3	329.0	364.7	391.9					
March 1999									
Benefits	328.4	343.0	377.8	409.5	442.9				
Premiums	37.6	40.4	44.4	48.7	53.1				
Net Benefits	290.8	302.5	333.4	360.8	389.8				
March 2000									
Benefits	308.4	318.7	347.8	373.4	401.7	432.5			
Premiums	34.2	37.2	40.3	43.6	47.2	51.0			
Net Benefits	274.2	281.5	307.5	329.8	354.5	381.5			
March 2001									
Benefits	313.7	331.7	360.6	389.1	420.3	454.2	499.3		
Premiums	36.8	39.6	43.4	47.1	50.9	55.3	60.4		
Net Benefits	276.9	292.1	317.2	342.0	369.4	398.9	438.9		
March 2002									
Benefits	293.1	308.5	335.0	361.2	389.0	418.9	454.1	482.7	
Premiums	32.1	35.0	38.6	42.1	45.8	49.6	53.8	58.2	
Net Premiums	261.0	273.5	296.4	319.1	343.2	369.3	400.3	424.5	
March 2003									
Benefits	305.0	317.6	341.2	364.6	390.9	419.4	453.6	480.2	522.0
Premiums	34.4	37.1	40.0	43.1	46.5	50.4	54.6	59.1	64.4
Net Benefits	270.6	280.5	301.2	321.5	344.4	369.0	399.0	421.1	457.7

Table 2.—Medicare Transfers as a Percentage of GDP Under Current Law and Various Scaled Drug Benefit Packages (Reflecting CBO's Spring 2003 Baseline)

Calendar Year	Spending Under Current Law	Spending Under a Drug Benefit with Costs over the 2006-2013 Period of:						
		$400 Billion	$500 Billion	$600 Billion	$700 Billion	$800 Billion	$900 Billion	$1 Trillion
2005	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.5
2010	2.6	2.9	3.0	3.1	3.2	3.2	3.3	3.4
2015	3.0	3.4	3.5	3.6	3.7	3.8	3.9	4.0
2020	3.4	3.9	4.0	4.1	4.3	4.4	4.5	4.6
2025	4.0	4.6	4.7	4.9	5.0	5.1	5.3	5.4
2030	4.7	5.4	5.5	5.7	5.8	6.0	6.2	6.3
2035	5.3	6.1	6.2	6.4	6.6	6.8	6.9	7.1
2040	5.8	6.6	6.8	7.0	7.2	7.4	7.6	7.8
2045	6.1	7.0	7.2	7.4	7.6	7.8	8.0	8.3
2050	6.5	7.4	7.6	7.8	8.1	8.3	8.5	8.7
2055	6.9	7.9	8.1	8.3	8.6	8.8	9.1	9.3
2060	7.4	8.5	8.7	8.9	9.2	9.5	9.7	10.0
2065	7.9	9.1	9.4	9.6	9.9	10.2	10.5	10.8
2070	8.6	9.9	10.1	10.4	10.7	11.0	11.3	11.6

Table 2.—Medicare Transfers as a Percentage of GDP Under Current Law and Various Scaled Drug Benefit Packages (Reflecting CBO's Spring 2003 Baseline)—Continued

Calendar Year	Spending Under Current Law	Spending Under a Drug Benefit with Costs over the 2006-2013 Period of:						
		$400 Billion	$500 Billion	$600 Billion	$700 Billion	$800 Billion	$900 Billion	$1 Trillion
2075	9.2	10.6	10.9	11.2	11.5	11.8	12.1	12.5

STATEMENT OF BRUCE STUART, PH.D., PROFESSOR AND DIRECTOR, PETER LAMY CENTER ON DRUG THERAPY AND AGING, UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY, BALTIMORE, MARYLAND

Dr. STUART. Thank you, Mr. Chairman, and Members of the Committee. I would like to use my brief remarks to address what I think is the most important question underlying the debate over a Medicare drug benefit, which is what will happen to beneficiaries if Congress fails to act. I hope to show you that recent trends in coverage put future beneficiaries at risk of having significantly reduced options for meaningful prescription benefits if legislative action is not taken soon.

Although a higher proportion of beneficiaries had some form of prescription coverage in 2000 than ever before, the growth is unsustainable. It is due to two phenomena, a rise in Medicare HMO enrollments and a rapidly growing segment of beneficiaries with ill-defined and overlapping benefits.

In fact, since 1995, there has been a slight decline in rates of drug coverage among beneficiaries who rely on a single prescription plan from an employer, a Medigap policy, Medicaid or other public program. By examining changes in these sources of coverage, we can develop a reasonably accurate forecast of what beneficiaries will face in the near future.

Retiree health benefits offered by employers and unions represent the most generous private source of prescription coverage available to Medicare beneficiaries. Data from the MCBS show that the number of beneficiaries with prescription coverage from employer plans has remained steady at 34 percent from 1996 through the latest data release for 2000.

This is actually a very surprising statistic, in light of the pullback in retiree health benefits reported by employers. According to annual Mercer/Foster Higgins surveys, the number of large employers offering employer coverage has dropped from 57 percent in 1987 to just 23 percent in 2001.

Why haven't we seen a comparable decline in the MCBS data? Preliminary results from a study my colleagues and I are conducting for the Commonwealth Fund suggests that the answer lies in beneficiary demographics. We find that the proportion of younger beneficiaries with employee-sponsored health benefits dropped dramatically between 1996 and 2000, while there was a small increase in coverage for beneficiaries 70 and older. This pattern does not auger well for future retirees.

The advent of Medicare+Choice in 1997 was followed by a major expansion in HMO enrollments. At the program's peak in 1999, more than 7.5 million beneficiaries had enrolled, yet 22 percent of

them left their plans that year, presumably for better coverage elsewhere.

The HMO enrollees represent a large fraction of the beneficiary population with shifting sources of prescription benefits and gaps in coverage. Today, M+C enrollment has declined by a quarter and the drug coverage offered by the remaining plans is less generous than it was 4 years ago.

Beyond M+C and employer coverage, the only other private source of prescription benefits available to beneficiaries is self-purchased coverage through a Medigap plan. In most States private carriers are permitted to offer three standardized plans with very limited benefit provisions that have not been updated in over a decade. Even this limited coverage may appeal to older people who have no other options.

The catch is that many carriers do not sell these policies and those that do generally charge high premiums. In some cases, the premiums exceed the maximum value of the prescription coverage itself. In other words the market for Medigap plans is ill-equipped to provide meaningful coverage to Medicare beneficiaries who lose benefits because of pull-backs in HMOs and employer plans.

The poorest elderly typically do not qualify for employer-sponsored health insurance and cannot afford the premiums for individual Medigap policies. Medicaid is available to those who meet stringent Federal and State means tests for income and assets. Some States have responded to the needs of those too poor to afford adequate medications, but not poor enough to qualify for traditional Medicaid by extending full Medicaid coverage to beneficiaries enrolled in the Federal Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiary programs.

Thirty other States have enacted pharmaceutical assistance programs that subside prescription drug expenses for selected low-income populations. The latest development is the CMS Pharmacy Plus waiver program that encourages States to develop drug-assistance plans paid for through savings in traditional Medicaid. Five States have approved Pharmacy Plus Programs and 10 others are in the process of developing waiver applications.

This flurry of activity at the State level might lead one to conclude that the needs of low-income Medicare beneficiaries are being adequately addressed. That would be a mistake. According to the MCBS, less than half of beneficiaries below the Federal poverty level are enrolled in Medicaid or another public program offering drug benefits during 2000. Only 1 in 5 beneficiaries, between 100 and 150 percent of the poverty line, was enrolled in a public plan.

The current patchwork of State programs is extremely fragile. Four of the 30 States that enacted pharmaceutical assistance programs have put them on indefinite hold because of budgetary problems. Massachusetts has frozen enrollments in its assistance plan. Some of the larger plans, including the Pennsylvania Program of All-Inclusive Care for the Elderly program are seriously underfunded.

Let me rephrase the central question I posed at the beginning of my remarks. What should Congress learn from these recent trends as it prepares to enact a meaningful drug benefit? The first lesson is that strong action must be taken to avoid further erosion in re-

tiree health benefits. Subsidizing prescription coverage will reduce the burden on employers, but additional steps will be necessary to assure that firms maintain or, better yet, improve upon current coverage.

Second, while managed care plans have clearly failed to provide meaningful drug benefits in the absence of government payment, it is just possible that covering drug costs in plan capitation rates may actually save the M+C program.

Finally, as important as State programs can be in filling the gaps in prescription coverage, present circumstances call for a unified national program of prescription benefits available to all Medicare beneficiaries.

Thank you very much.

[The prepared statement of Dr. Stuart follows:]

Statement of Bruce Stuart, Ph.D., Professor and Director, Peter Lamy Center on Drug Therapy and Aging, University of Maryland, Baltimore, Maryland

Mr. Chairman and distinguished Members of the House Ways and Means Committee. My name is Bruce Stuart. I am a Professor at the University of Maryland School of Pharmacy. I also direct the Peter Lamy Center on Drug Therapy and Aging which conducts research on Medicare beneficiaries' drug coverage, utilization, and outcomes. I am pleased to be here this morning to address what I believe should be the core question underlying the debate over a Medicare drug benefit; namely, what will happen to beneficiaries if Congress fails to act? I will show that recent trends in coverage put future beneficiaries at risk of having significantly reduced options for meaningful prescription benefits if legislative action is not taken soon.

First, the good news. The latest data from the Medicare Current Beneficiary Survey (MCBS) show that a higher proportion of beneficiaries had some form of prescription coverage in 2000 than ever before, reaching almost 79% of the beneficiary population with Medicare entitlement for the entire year. That is up from 69% in 1995. Moreover, a higher percentage of those with drug benefits in 2000 maintained them throughout the year than in any previous year for which we have data.

However, aggregate statistics can be misleading. The growth in prescription coverage between 1995 and 2000 is explained by two phenomena, a rise in Medicare HMO enrollment and a rapidly growing segment of beneficiaries with ill-defined and overlapping benefits. There was a slight decline in rates of prescription coverage among beneficiaries who relied on a single prescription plan from an employer, a Medigap policy, Medicaid, or other public program. By examining changes in these sources of prescription coverage, we can develop a reasonably accurate forecast of what beneficiaries will face in the near future.

Supplemental health benefits offered by employers and unions represent the most generous private source of prescription coverage available to Medicare beneficiaries. No one knows exactly how many beneficiaries are entitled to employer-sponsored coverage. Not all retirees given the opportunity of health insurance choose to take it either because of cost or alternative coverage. Data from the MCBS show that the number of beneficiaries with employer-sponsored health plans peaked in 1997 at 41% of the population and fell slightly to 39% in 2000. The proportion of beneficiaries with prescription coverage under employer plans has remained a steady 34% from 1995 through the latest data release for 2000. These are actually very surprising statistics in light of the pull-back in retiree health benefits reported by employers. According to annual Mercer/Foster Higgins surveys, the number of large employers offering health coverage to Medicare-eligible retirees declined from 57 percent in 1987 to 23 percent in 2001. Why haven't we seen a comparable decline in the MCBS data? Preliminary results from a study my colleagues and I are conducting for The Commonwealth Fund suggest that the answer lies in beneficiary demographics. Younger beneficiaries aged 65 to 69 are more likely to be affected by changing employer policies on retirement benefits than beneficiaries aged 70 and older. Based on MCBS data, we found that the proportion of beneficiaries with employer-sponsored health benefits in the younger age band dropped dramatically between 1995 and 2000, while there was a small increase in coverage for the older group. This pattern does not auger well for future retirees.

The advent of Medicare+Choice in 1997 was followed by a major expansion in HMO enrollments. At the program's peak in 1999, more than seven and a half million beneficiaries had enrolled. Yet 22 percent of them left their plans that year, presumably to get better coverage elsewhere. HMO enrollees represent a large fraction of the beneficiary population with shifting sources of prescription benefits and gaps in coverage. For example, 50% of those who disenrolled from an M+C plan in 1999 were left without prescription coverage. But even among those who stayed, only 65% were able to rely on M+C prescription coverage alone; 20% supplemented HMO drug benefits with other coverage, 7% had outside drug coverage and no M+C prescription benefits, and 9% had no prescription benefits from any source. Today, M+C enrollment has declined by a quarter, and the drug coverage offered by the remaining plans is far less generous than four years ago. Federal lock-in rules now scheduled for 2005 will presumably reduce the rate of M+C turnover, but that will not address the underlying reasons why beneficiaries move from plan to plan. Indeed, limiting beneficiaries' ability to leave plans that no longer meet their needs will make them worse off, and may well lead to further erosion in M+C enrollments. Plan withdrawals and rising premiums will have a similar effect.

Beyond M+C and employer coverage, the only other private source of prescription benefits available to Medicare beneficiaries is self-purchased coverage through a Medigap plan. In most States, private carriers are permitted to offer three standardized plans (H, I, and J) with maximum prescription coverage of $1,250 or $3,000 per year. All three plans contain a $250 deductible and 50% coinsurance. These benefit provisions were created by Federal law over a decade ago, and have not been updated. But even this limited coverage may appeal to older people who have no other options. The catch is that many carriers do not sell the policies that cover drugs, and those that do generally charge high premiums that in some cases actually exceed the maximum value of the coverage itself. According to MCBS data, the proportion of non-institutionalized beneficiaries relying only on these policies hovered around 9% between 1995 through 2000 (another percent or two mixed self-purchased plans with other coverage). The real number may be only half that high. Most experts believe that beneficiary reports of self-purchased drug coverage are inflated with the inclusion of discount cards and other plans that do not provide true insurance. Whatever the real number, the market for Medigap plans is ill equipped to provide meaningful coverage to Medicare beneficiaries who lose benefits because of pull-backs in HMOs and employer plans.

The poorest elderly typically do not qualify for employer-sponsored health insurance and can't afford premiums for individual Medigap policies. Medicaid is available to those who meet Federal and State means tests for income and assets. Dual enrollment in Medicare and Medicaid dropped slowly throughout the nineteen-nineties as a result of rising beneficiary incomes and static income-eligibility criteria. A slight up tick in 2000 may signal a reversal in this trend, but traditional Medicaid is still available only to the poorest poor. Some states have responded to the needs of those too poor to afford adequate medications but not poor enough to qualify for traditional Medicaid by extending full Medicaid benefits, including prescription coverage, to Medicare beneficiaries enrolled in the Federal QMB and SLMB programs. Other States (30 as of this writing) have enacted pharmaceutical assistance programs that subsidize drug expenses for selected low-income populations. An additional eight States have drug discount card programs for Medicare beneficiaries. The latest development is the CMS "Pharmacy Plus" waiver program that encourages States to develop drug assistance plans paid for through savings in traditional Medicaid. Five States (Illinois, Wisconsin, South Carolina, Florida, and Maryland) have approved Pharmacy Plus programs. Ten others are in the process of developing waiver applications.

This flurry of activity at the State level might lead one to conclude that low-income Medicare beneficiaries' needs for drug coverage are being adequately addressed. That would be a mistake. According to the MCBS, 48% of beneficiaries below the Federal poverty line were enrolled in Medicaid or another public program offering drug benefits during 2000. Only 20% of beneficiaries in the band between 100% and 150% of the poverty line were enrolled in a public plan. These proportions are not significantly higher than in 1995 when 46% and 18%, respectively, received such benefits. When data become available for 2001 and 2002, we may find that matters have improved. But even if that proves true, the current patchwork of State programs is extremely fragile. Four of the 30 States that have enacted pharmaceutical assistance programs have put them on indefinite hold because of budgetary problems. Massachusetts has frozen enrollment in its assistance program. Some of the largest plans, including the Pennsylvania PACE program are seriously under funded. The initial excitement surrounding the Pharmacy Plus program has turned to concern as States try to figure out how to pay for their new obligations without

gutting traditional Medicaid. Unlike the Federal Government, State prohibitions against running budget deficits mean that assistance programs are most vulnerable to cuts at precisely the time they are most needed.

Let me rephrase the central question I posed at the beginning: What should Congress learn from these recent trends as it prepares to enact a meaningful Medicare drug benefit? My optimism is based on the belief that our government will simply not permit the gains in drug coverage won by Medicare beneficiaries during the nineteen-nineties to be needlessly lost. The first lesson is that strong action must be taken to avoid further erosion in retiree health benefits. Subsidizing prescription coverage will reduce the burden on employers, but additional steps will be necessary to assure that firms maintain—or better yet—improve upon current coverage. Second, while managed care plans have clearly failed to provide meaningful drug benefits in the absence of government payment, it is just possible that including drug costs in plan capitation rates may actually save the M+C program. Finally, as important as State programs can be in filling gaps in prescription coverage, present circumstances call for a unified national program of prescription benefits available to all Medicare beneficiaries.

Thank you.

Mr. MCCRERY. Dr. Pauly?

STATEMENT OF MARK V. PAULY, PH.D., PROFESSOR, HEALTH CARE SYSTEMS, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

Dr. PAULY. Thank you, Mr. Chairman and Members of the Committee. I have directed my prepared remarks at the issue of prescription drug coverage, but I would be happy to comment on the general issue of Medicare reform.

The absence of outpatient prescription drug coverage for the quarter to a third of Medicare beneficiaries who don't get such coverage poses for them a serious risk of both high out-of-pocket payments and the risk that they will fail to use drugs that are effective for their health and so be of concern to their fellow citizens. Are there ways to improve the situation?

I believe that there are and that the best design for improvement that pays attention to the budget constraints for Medicare as a whole is one that builds on two important principles of public policy. First, that protection against financial risk should be based on a correct theory of insurance and, second, that coverage of concern for public policy should help people with low incomes pay for drugs they might otherwise forego, but that concern need not extend to beneficiaries with lower levels of spending and higher incomes who are able to pay for their drugs.

I, first, consider the design of insurance coverage to maximize value. That is what we are trying to do here. This design is based on the common-sense principle that underlies all insurance. The purpose of insurance is to provide benefits when they are most needed.

For the financial protection dimension of insurance, it is obvious that benefits are most needed when losses are greatest, since in such cases the threat to wealth and future standard of living is greatest. In contrast, insurance coverage is of low value, if it pays for low or below-average levels of expense. Since insurance itself always carries an administrative cost, such budgetable expenses usually should not be insured at the real cost of using resources to review claims and write checks.

Insurance is supposed to pay for the rare high-cost event that spells financial disaster and not for the modest expense most people could reasonably expect year-after-year and could afford if it did occur. Insurance which did pay for small, predictable expenses would be insurance in name only. For the Medicare population, it would be roughly equivalent to an increase in Social Security payments, but made in a less transparent and less-efficient way.

What about people who, because of the absence of insurance, failed to use beneficial care? We know for certain that the volume of drug use and drug spending is increased when insurance coverage is greater. This phenomenon of moral hazard mentioned earlier occurs for people at all income levels. In effect, insurance makes expensive drugs look cheap and inexpensive drugs look dirt cheap.

This lower price appears to have an amazingly strong effect on everyone's behavior. For example, our research indicated that lowering the copayment for prescription from $10 to $2 could produce up to a 65-percent increase in drug expenditure for people under age 65 who are middle class, privately insured, and the same order of magnitude is probably true for seniors.

The evaluation, of course, of the increase in spending is uncertain. Some portion of it represents increase in spending that would receive social approbation. Other portions though, may represent the use of products which, even if of positive value, were not really worth what they cost.

These two principles can be made highly consistent if we assume that lower income is associated with a lower use of drugs, other things equal, and that such low use is a matter of social concern. Then, the socially optimal coverage policy in a budget constraint world would provide virtually complete financial protection for those beneficiaries with incomes just above the Medicaid limit.

In contrast, for the elderly middle class, who are about half of the elderly, the insurance of concern to government should cover expenses more generously as expenses rise, but should provide no coverage for small expenses, with the point of which coverage begins to take effect related to household income and wealth. A very simple version of such a scheme would involve insurance that provides full coverage of a deductible, with the deductible stated as a percentage of household income.

There are two objections to this simple, but powerful model:

First, because drug expenditures are not evenly spread over the population, some people criticize this model because most people will not collect from their insurance, but will either have to pay something or, even if the insurance is fully paid by taxes, will be miffed at not getting an equal slice of government largesse.

As suggested earlier, if those unlucky people who have low drug expenses in a given time period need to receive a political payoff, providing low deductible or first-dollar coverage is an inefficient and inequitable (to those with zero expenses) way to do so; just increase Social Security with a cost of living adjustment that includes drug spending as a component.

Of course, whether low risks are in or out, a somewhat more respectable argument is one that views front-end coverage as a way of dealing with adverse selection. The main problem with the argu-

ment here is that adverse selection only helps the high risks if the low risks can be induced to pay more than the value of their benefits, but because the benefits for low risk are so small and so predictable, there is very little willingness to pay extra.

I will also make just a few comments on how to pay for drugs. I have talked about the form of insurance coverage. The general principle of insurance here is pretty straightforward. The idea would be to pay an indemnity benefit that would cover products that are sold in competitive markets, and that might be a reasonable principle for generic drugs, although the Federal Trade Commission should continue to be vigilant about pricing of those products.

The most serious problem arises, however, for products protected by patents. Society offers patents in order to induce drug firms to invest in research & development for new products. Once products are invented and fixed costs have been incurred, however, it is desirable to get final selling prices down. So, our choice, actually, is between cheap products now and good products later, but not between cheap, good products now and cheap, good products later.

Thus, the part of the government that wants to contain medical costs is at war with the part that wants to foster medical progress. It is certain that if research & development is undertaken by rational profit-maximizing firms, lower prospective prices and payments will mean fewer good, new products. The key, obviously, is what are the nature of the good products that would be foregone. They would probably include orphan drugs and some things of substantial value.

In the face of such uncertainty about what public policy might affirmatively do, in my judgment, the best policy is to try again to replicate as much as possible markets with patents that are otherwise competitive. This situation would be best accomplished if individuals could choose from a large number of different health plans, with the plans having different policies as to which drugs they pay for, what prices they pay and what advice and assistive services they provide.

When there is a choice of plans, those plans must be allowed to differ in both coverage policies and premiums paid by the insured for choice to be meaningful. It does not help if there are multiple contractors administering exactly the same coverage at the same beneficiary premium.

Competition between different plans cannot be guaranteed to yield lowest possible price, I think it is important to emphasize, but it probably will lead to the best price and the best tradeoff between price and quality that reflects the tradeoffs beneficiaries are willing to make between the different types of cost containment that provides incentives to squeeze out any insurer profit and that best deals with government-granted patent monopolies.

My final comment, and in some ways saving the worst for last or, in some ways, the best for last, we know that the primary reason why health care costs rise in this country is because of the addition of beneficial, but costly, new technology. I think there are serious doubts about our ability to afford, certainly for public programs, and perhaps even privately, the rate of growth of beneficial, but new, technology that we have become used to over time. We

live and will live in a world of limited resources, some technology should not be made available to all who will benefit from it, but we have found no institutional structure for saying, "No." There is no institutional structure for making such cost-benefit tradeoffs and especially not for government-funded coverage like Medicare.

So, three policy questions remain:

First, how low a deductible at any given income level represents the appropriate combination of financial protection for seniors, appropriate incentives to use, but not overuse, drugs, and tax burdens on present and future taxpayers?

Second, what tradeoffs should we make between inexpensive drugs today and better drugs for the future?

Third, and most importantly, what rate of increase in spending for higher quality, but more costly, products we think is appropriate for the growing number of elders in our country?

Thank you very much.

[The prepared statement of Dr. Pauly follows:]

Statement of Mark V. Pauly, Ph.D., Professor, Health Care Systems, Wharton School, University of Pennsylvania, Philadelphia, Pennsylvania

The absence of outpatient prescription drug coverage for those non-poor Medicare beneficiaries who did not have a job at a firm that offered drug coverage as a retirement benefit leaves a serious gap. This gap exposes a quarter to a third of beneficiaries to the risk of high out of pocket payments for drugs or to the risk that they will underuse drugs that are effective for their health, and so be a concern to their fellow citizens. Unsubsidized Medigap markets, required to undertake some community rating, are plagued with adverse selection because high prescription drug expenses are usually associated with chronic conditions with highly predictable drug expenses and consequent severe adverse selection. Are there ways to improve this situation?

I believe that there are, and that the best design for improvement is one that is built on what (in my view) ought to be two important principles of public policy: (1) protection against financial risk should be based on a correct theory of insurance, and (2) coverage of concern for public policy should help people with low incomes pay for drugs they might otherwise forego, but that concern need not extend to beneficiaries with lower levels of spending who are able to pay for their drugs. I will elaborate on the implications of these two principles, and then suggest what they imply for practical benefits design and realistic public policy. Throughout, I will be sensitive to a third important aspect of public policy: even current levels of Medicare benefit are threatened, once the baby boom generation reaches retirement age, by high Medicare costs relative to levels of support at current tax rates; the feasibility of substantial increases in the distortive taxes paid for Medicare (largely by younger workers) is limited and therefore any new benefit should add as little as possible to the tax burden. Drug benefits for some parts of the Medicare population in some circumstances are of sufficient value to justify some increase in payment and taxes, but these increases should be kept as modest as possible.

I first consider the design of insurance coverage to maximize value. This design is based on the common sense principle which underlies all insurance. The purpose of insurance is to provide benefits when they are most needed. For the financial protection dimension of insurance, it is obvious that benefits are most needed when losses are greatest, since in such cases the threat to wealth and future standards of living is greatest. In contrast, insurance coverage is of low value if it pays for low (below-average) levels of expenses; since insurance itself always carries an administrative cost, such budgetable expenses usually should not be insured at the real cost of using resources to review claims and write checks. Insurance is supposed to pay for the rare high cost event that spells financial disaster, and not for the modest expense most people could reasonably expect year after year, and could afford if it did occur. Insurance which did pay for such smaller predictable expenses would be insurance in name only; it would really be an income transfer (largely equivalent, for this population, to an increase in Social Security payments), but done in a less transparent and less efficient way. Put more explicitly, the rational and valuable insurance is coverage against financial catastrophes, and only such coverage is warranted on the basis of financial protection.

What about the role of insurance as assistance to people who otherwise would not choose to obtain beneficial care? We know for certain that the volume of drug use and drug spending is increased when coverage is greater; this phenomenon occurs for people at all income levels. In effect, insurance makes expensive drugs look less expensive, and inexpensive drugs look dirt cheap; this lower price appears to have an amazingly strong impact on everyone's behavior. For example, research indicates that lowering the copayment per prescription from $10 to $2 can produce a 65 percent increase in drug expenditure for privately insured middle class non-elderly, and the same is probably true for seniors.

While the increase in use with coverage is certain, the social evaluation of this increase is uncertain. It may represent the use of highly beneficial drugs that reduce illness, frailty, and poor functional status about which there is substantial concern by others in the community. On the other hand, especially for beneficiaries who are not poor and not suffering from serious chronic conditions, this increased use may represent spending of low value (even if it is positive) relative to its cost. Since that cost must be paid by some other taxpayers if not paid by the beneficiary, those taxpayers may correctly judge this increase to be inefficient and unfair.

These two principles are highly consistent if we assume that lower income is associated with lower use of drugs, other things equal, and that such low use is a matter of social concern. Then the socially optimal coverage policy would provide virtually complete financial protection for those beneficiaries with incomes just above the Medicaid limit. In contrast, for the middle class households that predominate among the elderly, the insurance of concern to the government should cover expenses more generously as expenses rise, but should provide no coverage for small expenses, with the point at which coverage begins to take effect related to household income and wealth. A very simple version of such a scheme (though one that can be fine tuned if need be) would involve insurance that provides full coverage above a deductible, with the deductible stated as a percentage of household income. Refinements of this approach might make the required deductible a smaller percentage of income for lower income households ("progressive deductible"), and might provide a corridor of coverage with percentage coinsurance before full coverage kicks in.

Spreading the Gains and Adverse Selection

There are two objections to this simple but powerful model. First, because drug expenditures (like all losses for which insurance is rational) are unevenly distributed over households, within any time period some households (those with low or zero expenses) will get no insurance benefits, while a few households with very large expenses will get large benefits under catastrophic insurance. This is the way insurance is supposed to work, redistributing benefits from lucky people who are not ill and have low expenses to the few most unfortunate who have the greatest need for help. There is a cynical political view that American voters are unable to support an insurance plan which is based on catastrophic insurance principles, because "most people will not collect anything from the insurance," but will either have to pay something or, even if the insurance is fully paid by taxes, will be miffed at not getting an equal slice of government largesse.

That argument has no support in any view of the political process as one that makes rational decisions to maximize the general well being of society or of a targeted population like senior citizens. In my view, Congress should play an educational and leadership role in explaining to citizens (who really and truly do understand it) that it is not in the long run desirable that most people "make money" from insurance; instead, insurance is supposed to help out the most unlucky. As suggested earlier, if those "unlucky" people who have low drug expenses in a given time period need to receive a political payoff, providing low deductible or first dollar coverage is an inefficient and inequitable (to those with zero expenses) way to do so; just increase Social Security benefits to keep with a "cost of living" that includes drug spending as a component. If some upfront health-related benefit must be offered to lower income people, it should be as flexible as possible (for example, usable for out of pocket payments or supplemental insurance to buy down the deductible), and not be pre-specified to be a particular percentage coinsurance.

A somewhat more respectable argument is one that views "front-loaded" benefits as a possible response to adverse selection. Adverse selection is such a complicated and poorly understood phenomenon in health insurance that it can be used to justify almost anything. The notion here is that, if people can estimate in advance whether they will have high or low drug expenses in a given year, and if there is a positive uniform premium for voluntary catastrophic coverage, such coverage will not appeal to those with low expected expenses. They will not enter the risk pool, thus raising the average benefit per person in the pool. Of course, whether lower risks are in or out has no impact whatsoever on the actual expenses by or benefits to the higher

risks, but the cosmetic effect of having a lower average benefit cost is thought to be desirable. More substantively, it is felt that if the lower risks are not "contributing," that somehow means that the subsidy to the higher risks will need to be greater.

Such a phenomenon is unlikely. But having the lower risks in the pool helps out the higher risks only if the amount of premium charged to the lower risks is in excess of their average claims, so that they cross subsidize the higher risks. But, especially in prescription drug insurance with high predictability of expenses in the short run, the lower risks will be unwilling to pay much above their expected claims. The claims are small and so pose little risk, and the claims are highly predictable. I take a medicine for a chronic condition that costs $30 per month but am otherwise healthy. I will not be willing to pay much more than $360 per year for drug insurance; I cannot be induced to cross subsidize voluntarily. Unless lower risks are terribly risk averse, there is no financial benefit from keeping them in the pool.

How to Pay for Drugs

The general principle of insurance reimbursement is simple. The price or loss should be determined in competitive markets, and then insurance should indemnify insureds against some portion of that loss. The insurance should pay an indemnity whose value depends only on what the person's illness is and the competitive expense for treating that illness. The price paid should be the market price, and should ideally be unaffected by and independent of the presence or absence of insurance.

The principle of leaving price setting to the competitive market might work for drugs sold in competitive markets, such as generic drugs, although even here FTC oversight will be important. However, for drugs protected by patents, the situation is more complex. Patents are a government-granted monopoly for a limited period of time in order to provide incentives for research on and development of new products. The dilemma for citizens and for government agencies is this: once products are "invented" and fixed costs have been incurred, it is desirable to get final selling prices down. But such a strategy offers low priced existing products only at the cost of less development of new products. Thus the part of government that wants to contain medical costs is at war with the part that wants to foster medical progress. It is certain that, if research and development is undertaken by rational profit maximizing firms, lower prospective prices and profits will mean fewer new products. The key question here obviously is that of the value of products foregone relative to the benefits from lower prices, but no researcher or policymaker knows the answer to that question. For the present, we must plan policy in ignorance.

In the face of such uncertainty about what public policy might affirmatively do, probably the best policy is again to try to replicate (as much as possible) markets with patents that are otherwise competitive, especially on the buyer or insurance side. Buyers should be free to walk away from products whose price is higher than what buyers think they are worth, but no set of buyers should be permitted to collude or combine to force prices down. This situation would best be accomplished if individuals could choose from a large number of different health plans, with the plans having different policies as to which drugs they pay for, what prices they pay, and what assistive services they provide. One would expect plans to impose some copayments that signal to insureds when covered drugs are sold at especially high prices relative to other alternatives; "triple tier" copayment or simple proportional coinsurance will accomplish this goal. I believe there is also merit in trying to approximate an indemnity payment conditional on the need for some drug in a given therapeutic class; the German health system model of reference pricing, in which a fixed amount adequate to buy one product in a class is paid but patients are free to buy more expensive products with their own money. More elaborate versions in which some fraction of the incremental cost is covered are also possible.

When there is a choice of plans, these plans must be allowed to differ in both coverage policies and premiums paid by the insured for choice to be meaningful; it does not help if there are multiple contractors administering exactly the same coverage at the same beneficiary premium. "Competition" between different plans cannot be guaranteed to lead to the lowest possible price, but it probably will lead to the best price, the price that best reflects the tradeoffs beneficiaries are willing to make between different types of cost containment, that squeezes out any insurer profit, and that best deals with government granted patent monopolies.

Final Comments

Although the case for catastrophic insurance coverage for seniors that extends to prescription drugs is overwhelming, the addition of that coverage makes Medicare's

long run future even more difficult to plan. The reason is that rising medical care and health insurance expenses are almost always driven by the addition of beneficial but costly new technology, and because pharmaceuticals have been the leading source of that new technology. Because we live (and will live) in a world of limited resources, some technologies should not be made available to all who would benefit from them. However, we have no institutional structure for making such cost-benefit tradeoffs, especially not for government-funded coverage like Medicare. The model of a panel of wise and dispassionate scientists determining coverage for all, tried in some other countries, has some serious problems; to let Congress decide on (and be lobbied about) coverage is even worse. My own suggestion would be to make a social decision about what level of contribution for Medicare is financially sustainable; make that amount of funding available to beneficiaries, and let them use it for a variety of loosely limited competing plans. See how this works, and only add to the budget if serious problems of access to highly beneficial products emerge. Such a strategy may be the best one for a constrained and uncertain future.

Three essentially political questions remain: (1) How low a deductible at any given income level represents the appropriate combination of financial protection for seniors, appropriate incentives to use (but not overuse) drugs, and tax burdens on present and future taxpayers? (2) What tradeoffs should we make between inexpensive drugs today and better drugs for the future? And (3), most importantly, what rate of increase in spending for higher quality but more costly products do we think is appropriate for the growing numbers of elderly in our country?

Mr. MCCRERY. On that sobering note, we will go to Dr. Reinhardt.

STATEMENT OF UWE E. REINHARDT, PH.D., PROFESSOR, ECONOMICS AND PUBLIC AFFAIRS, DEPARTMENT OF ECONOMICS AND THE WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NEW JERSEY

Dr. REINHARDT. Thank you, Mr. Chairman, and Members of this Committee for inviting me to share my views on Medicare reform. I will concentrate mainly on Medicare reform and not on the prescription drug coverage. I am working on a paper on it. I haven't totally through. Once I have, I will be happy to share on that.

Now, my testimony grew out of a primer I had written for journalists who always kept asking the same questions and to be efficient, I just wrote this up and said call me back if it is not clear.

The questions I was asked: What are the deficiencies of the traditional program and who is responsible for those deficiencies?

The second question: What form should the competition between traditional Medicare and private insurance plans take?

The third one was what are actually the goals of Medicare reform and are these achievable?

Finally, what are some of the technical and political obstacles?

Now, with respect to the shortcomings, the interesting thing is Medicare is a highly popular program. Survey after survey shows that if you array public and private insurance products, Medicare usually is among the top or the winner. So, you are trying to reform a program that is highly popular among not only the old, but also the young. It has shortcomings, and we have heard these. It has a strange insurance structure. It has no stop-loss protection, no catastrophic protection, doesn't cover prescription drugs.

I am asked who is responsible for it? The culture and language is bureaucracy. The word "bureaucracy" in America is a little bit like the word "French" is these days. It is always not good.

I analyzed it, and I would defy anyone to prove me different. All of the shortcomings of the traditional Medicare program are the Congress' responsibility. Think of Medicare as an insurance company. The management is the Health Care Financing Administration (HCFA) and now CMS. You are the board of directors. Then look down what good governance would require, and you would find the fault lies in the board of directors.

If Medicare doesn't have prescription drugs, that is Congress' fault. If there has never been successful competitive bidding, that is Congress' fault.

I noticed Mr. Walker said that Medicare overpays for prescription drugs for oncologists, but straight shooter that he is, he points out on page 20, that it is in the statute. There is nothing CMS can really do about it. So, that is the first thing. There is no reason why this body, the board of directors, could not fix the deficiencies that are in Medicare, and there are many proposals around on the shelf to do this. This is not rocket science.

The next question that gets asked is: What should be the nature of the competition? I think the reasons why some people feel that the proposals now before the Congress are actually out to destroy the existing Medicare is the idea to put $400 billion of taxpayer money and give that only to the private health plans as a come-on and not to put a drug benefit also in the traditional Medicare.

That would, of course, be a policy quite consciously designed to destroy the old Medicare. Maybe that should be done, but it should be openly discussed as such. I think camouflaging that with pretty language does seem to me to be not proper in a democracy.

The next question comes: What are actually the objectives of this reform? Here I have the most difficult problems with journalists. I, myself, I have heard again many times this morning that we need to reform Medicare. What are we really talking about?

I list on page 7 of my testimony several goals, but let me pick on just two. If the idea is that Medicare reform will lower total health spending per elderly from all sources, I would almost assure you that will not be achieved. I have a chart on page 8 where I say, "Where could those savings come from?"

Would you believe that private health plans can get lower fees than the traditional Medicare? I don't think so.

Would you believe that you can reduce volume more than the traditional Medicare? Well, we have the managed care backlash. We have just been through it, and the Supreme Court now completely killed HMOs by having this "any willing provider" provision.

So, the idea that you think you can reduce volume with private health plans in Dade County, Miami, and not trigger a backlash among the elderly, I doubt it. I think you will find there isn't that much volume, unless Congress really gets control, unless you get into it.

When it comes to SG&A, savings and administration, Medicare now spends less than 2 percent of the total expenditure on administration. I will put to you the proposition there is no insurance

company in America that could run an insurance program this complex and spend only 2 percent on administration. In addition, they would have to market individually to the elderly, which Medicare does not, and they would have to give profits to shareholders, which Medicare does not.

So, I believe there is no source of saving in SG&A. I think in chart A, I can ask my colleague here to audit it, I don't think I have left anything out. This is, again, not rocket science. I put it all out there, and anyone who would argue that you can save total spending would have to tell me where in this map would you do it.

Now if, on the other hand, the idea is to let total spending go where it may, but to limit just the taxpayers' exposure, that of course you could do. The idea there would be to lighten the burden on the working population who pays payroll taxes and shift it to the elderly themselves. I think that could be debated, but I would think, in a democracy, that should be put honestly on the table for all the young and the elderly to see, so that one could have a forthright, democratic debate on this—democrat "small"—rather than hiding that under some other goal.

There are some obstacles that I see. The CMS—or HCFA formerly—has never succeeded to experiment with competitive bidding, yet competitive bidding is a core of this reform. So, ask yourself how would the health plans ever play along? They like administered prices because they can manipulate them. I don't think they would like competitive bids.

We don't have a good risk-adjustment mechanism. The Dutch don't, we don't, the Germans don't, and yet having a good risk adjuster is the sine qua non of a competitive insurance structure. We heard about the Winberg variations this morning.

Finally, I do ask Medicare can't ever really compete fairly with private plans because, say, Humana can pull out of Iowa if they don't like it, but Medicare has to stay as the insurer of last resort. So, it will be very difficult ever to have a really level playing field in this field.

Those are my remarks. Thank you.

[The prepared statement of Dr. Reinhardt follows:]

Statement of Uwe Reinhardt, Ph.D., Professor, Economics and Public Affairs, Department of Economics, and Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, New Jersey

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University's Department of Economics and the Woodrow Wilson School of Public and International Affairs. At this hearing, I represent only my own views as a health economist and health policy analyst, and not those of any other person or institution.

I would like to thank you, Mr. Chairman and your colleagues on this Committee for the opportunity to share with you my observations on proposals to extend coverage for prescription drugs to Medicare beneficiaries as part of a reform of the entire Medicare program.

My statement before you, submitted for the hearing record, draws on a longer *Primer for Journalists on Medicare Reform Proposals*, which I have submitted to your Committee as well. It can be accessed at website http://www.wws.Princeton.EDU/~chw/memberf.html (Click on "Uwe Reinhardt" and then on "Medicare Reform").

The *Primer* was written in response to several inquiries by journalists on the Medicare reform proposal released by President Bush in early March. In the *Primer*, I have sought to comment on four questions frequently posed by journalists:

A. What are the deficiencies of the traditional Medicare program, and who is responsible for them?
B. What form should the competition between traditional Medicare and private insurance plans take?
C. What are the goals posited for the proposed Medicare reform proposals, and are these goals achievable with the proposed reform?
D. What might be the technical and political obstacles to such a reform?

In what follows, I shall respond to each of these questions. I assume throughout that the reform in question is the one sketched out in general terms by President Bush on March 3rd, 2003, although that proposal is so sketchy that one could easily, and quite inadvertently, do it injustice. But similar proposals had been proposed earlier by Senators John Breaux and Bill Frist, and by the *Bipartisan Commission of the Future of Medicare* in the mid 1990s. The general idea of these proposals is to have Medicare delegate the tasks of managing the cost of health care benefits and their quality to private health plans that would bid competitively for the Medicare business. All such plans, however, would allow Medicare beneficiaries to stay with the traditional Medicare program, in its current form.

The purpose of my testimony—and of my *Primer for Journalists on Medicare Reform*—is not been to advocate a particular reform plan or to oppose one. The intent has merely to raise a series of questions that have either not been raised before or have never been satisfactorily answered, if they have cropped up before. The testimony, Mr. Chairman, is submitted to your Committee in that spirit.

A. THE POPULARITY AND SHORTCOMINGS OF TRADITIONAL MEDICARE

The Abiding Popularity of the Program: In their recent paper "Medicare Versus Private Insurance: Rhetoric and Reality" (available on the *Health Affairs Web Exclusive*, October 9, 2002), health services researchers Karen Davis, Cathy Schoen, Michelle Doty and Katie Tenney report on a national survey of some 3,500 adults, and conducted in mid 2001, according to which "Medicare beneficiaries are more satisfied with their health care under traditional Medicare than are persons under age sixty-five who are covered by private insurance."

This finding corroborates an earlier survey in 1998 by the Henry J. Kaiser Family Foundation entitled "National Medicare Policy Options Survey" (available on website http://kff.org), which similarly found that the traditional Medicare program earns very high marks among public and private health insurance products among Americans, both young and old.

The Program's Shortcomings: The popularity of traditional Medicare is all the more remarkable, because that program does have serious deficiencies, to wit:

1. It does not cover prescription drugs or long-term care other than that associated with an acute-care episode.
2. It does not provide adequate catastrophic stop loss protection.
3. It calls for considerable cost-sharing by patients at point of service—for example, $840 for the first day in a hospital episode, $210 per day for hospital stays in excess of 60 days, $420 per day for stays exceeding 60 days, and all costs for stays exceeding 150 days.

Indeed, because of its spotty benefit package, Medicare currently pays for only about 52% of the total health spending for Medicare beneficiaries (from all sources). Medicaid pays for another 12% and private insurers (so-called *Medigap* coverage provided by former employers or purchased directly by beneficiaries) another 12%. The beneficiaries themselves pay for 19% of their total spending out of pocket at point of service. For low-income beneficiaries, their out-of-pocket costs for health care tends to be around 30% of their meager incomes.

The abiding popularity of the traditional Medicare program—in spite of its deficiencies—probably reflects three factors.

First, unlike virtually all other private or public insurance products in this nation, which tend to be ephemeral, Medicare coverage is permanent. It does provide its beneficiaries with the genuine sense of security not enjoyed by most other insured Americans, which is a decided plus, especially for elderly people.

Second, Medicare traditionally has offered beneficiaries completely free choice of providers and completely free choice of therapy for covered services. Usually, private insurance products have a variety of restrictions in this regard.

Finally, most Medicare beneficiaries have plugged the gaps in coverage left by traditional Medicare with Medigap policies, or Medicaid comes to their rescue.

Responsibility for the Medicare's Current Shortcomings: It is customary among critics of traditional Medicare to blame its shortcomings on its "unwieldy bureaucracy," the Department of Health and Human Services Centers for Medicare

and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). Among people with distaste for government, that theory has great currency.

A major point I make to journalists is that this accusation is a bum rap. Responsibility for Medicare's shortcomings rests almost wholly with the program's Board of Directors—the Congress of the United States. For example:

> *If the traditional Medicare program does not cover prescription drugs, it is so because the collective will of the Congress of the United States has willed it so.*
>
> *If the traditional Medicare program does not work as a prudent purchaser with selective centers of excellence or with other preferred providers known to give cost-effective care, it is so because Congress has expressly forbidden that kind of contracting and prudent purchasing.*
>
> *If the traditional Medicare program does not engage in "disease management" or "managed care" of any type, it is so because Congress has not permitted Medicare to pursue these avenues.*
>
> *If the traditional Medicare program has hardly ever had the benefit of being able to solicit competitive bids for the products and services it purchases on behalf of beneficiaries, it is so because the Congress has willed it so.*

Until the early 1990s, private health insurers typically did not cover prescription drugs either. Virtually none of them employed any utilization or cost controls, and most of them paid providers whatever they were billed by the providers of health care, rather than negotiating fees. Consequently, throughout most of the 1980s, Medicare spending per beneficiary rose much less rapidly than did the (per capita) premiums charged by private health insurers. As is well known, that differential in favor of Medicare is observed today as well.

To be explained, then, is why Congress decided to sit on its hands during the 1990s, as private insurers began to modernize their approach to health insurance and cost containment. It is a question not properly posed to CMS. It is a question properly addressed to the Congress itself, which failed to expand Medicare's benefit package in step with modern clinical developments, and which incessantly micromanaged Medicare's bureaucracy, preventing the very innovations whose absence are now being deplored, sometimes by Members of Congress themselves.

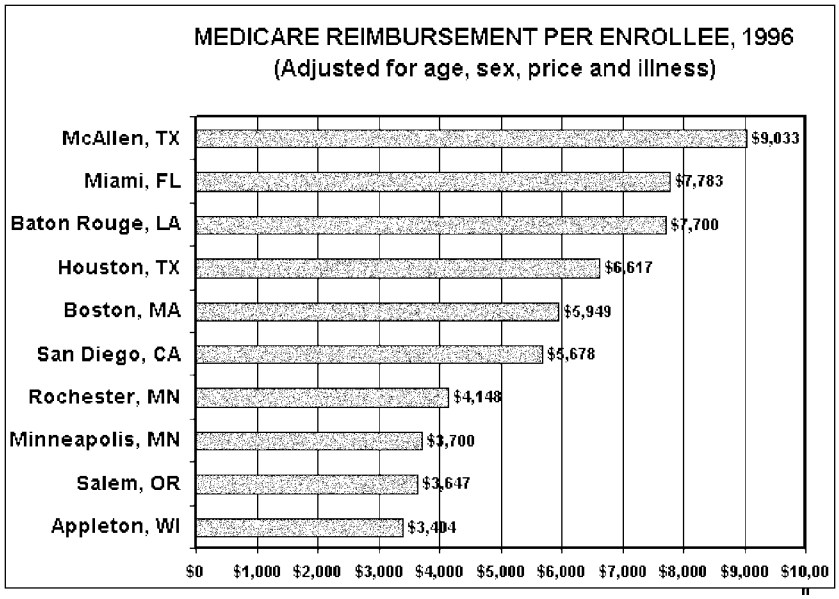
To illustrate, how can the Congress justify to the American people that it has budgeted for Medicare an administrative overhead allowance of less than 2%. No private health insurer could possibly manage so large and complex a program at so low an expense ratio? Congress' posture on this budget item seems almost designed to prevent Medicare from managing its affairs effectively. Why is this so?

Similarly, how can the Congress justify to the American people that the budget for operations research it appropriates for the CMS (about $15 million a year) is only about 0.0038% of total spending by the CMS? Consider, if you would, the graph on the next page. For decades Congress has been apprised by health services researcher John H. Wennberg, M.D. and his associates at Dartmouth University that, even after adjustment for inter-county differences in the age-gender composition of the elderly population, of case-mix severity and of practice costs, Medicare spending per statistically equivalent beneficiary varies by a factor of three across the nation (see the graph below). Remarkably, Congress has never shown any interest in funding research that might uncover what difference such spending differentials might have on the quality of the beneficiaries' lives. It is all the more remarkable as the Congress expresses concern over the economic implications of the retiring Baby Boom. After all, if physicians in many of the Sunbelt States were to adopt the more conservative practice style of, say, the Mayo Clinic in Rochester, Minnesota, the retiring Baby Boom really would not be a major economic problem for this relatively young nation.

Finally, how can the Congress justify to the American people that, during the 1990s, it has consistently intervened with the bureaucracy on behalf of the health insurance industry, preventing experiments with competitive bidding for the Medicare business by private health plans? To quote in this regard from an analysis of this remarkable record by Bryan Dowd, Robert Coulam and Roger Feldman:

> *Most Medicare reform proposals would replace the current payment system with some for competitive pricing [of insurance products]. However, efforts over the past five years to demonstrate competitive pricing for M+C plans have been blocked repeatedly by Congress, even when the demonstrations were directly responsive to a congressional mandate. In the absence of political support, a demonstration of competitive pricing may be infeasible, and Congress could be forced*

to take the risky step of implementing broad Medicare reforms with very little information about their effects." [1]



Source: John E. Wennberg et al., *Dartmouth Atlas of Health Care 1999*, AHA Press, 1999: Chapter One Table, pp. 33–40.

Viewed in their entirety, Congress' policies on traditional Medicare convey the impression that Congress has deliberately stunted the evolution of Medicare in step with modern clinical and organizational developments. It is fair to inquire why that is so.

B. WHAT FORM SHOULD COMPETITION BETWEEN TRADITIONAL MEDICARE AND PRIVATE HEALTH PLANS TAKE?

As a general rule, it is always a good idea to subject publicly administered programs to competition from private-sector entities capable of delivering the same benefits, where that is feasible. For that reason, one should welcome any reform that sets up a *fair* and *intellectually manageable* competition between the traditional Medicare program and equivalent private-sector health insurance products, if only to offer citizens a wider choice—the ability to exit a relationship with the public program.

The Virtue of Choice: We take it for granted that "more choice" always is to be preferred to "less choice" in the design of social programs, even though modern behavioral economists would warn us that there can be such a thing as too much choice. It happens when choices set before individuals are not accompanied by adequate information on these choices. It also happens when the sheer complexity of the choice menu overwhelms the individual's capacity to make rational choices.

If the Administration and the Congress wish to confront Medicare beneficiaries—especially the frail elderly—with ever more complex choices in health insurance, it is incumbent upon government to accompany these choices with clear information about them and to structure them so as to make rational choice manageable by ordinary human beings. In this regard, one is not at all assured by the recent headline that "Medicare Officials Order End to Instructive Services" (*The New York Times*, January 25, 2003, p. A12). The article opens with the statement:

---

[1] Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs*, September/October, 2002; pp. 9–27. This volume of Health Affairs contains several other papers and commentaries on the issue of competitive bidding.

"Running short of money, Medicare officials have ordered immediate cuts in a wide range of services that provide information, advice and assistance to Medicare beneficiaries."

Once again, the temptation here is to blame the "Medicare bureaucracy" for this budget reallocation. As I have noted above, the fault really lies with Congress' insufficient appropriation for Medicare's administrative expense.

Be that as it may, if this is an augury to come for Medicare reform, then "more choice" may well end up as "more confusion" among beneficiaries and "more regret" and disillusionment *ex post*. If Congress really seeks to reform Medicare along the lines proposed by the President, then Congress must show better faith in regards to the information infrastructure the reform presupposes.

The Fairness of Competition: The next question is what form the competition among alternative insurance products in Medicare should take. Two distinct visions of this competition are now put before the American people.

One arrangement would be to style the choice and competition among health insurance products as one between (a) a *modernized*, government-run Medicare program that includes prescription drugs, preventive care and catastrophic coverage, and that is allowed by Congress to use techniques of modern "managed care" and (b) equivalent private-sector insurance products managed by private health plans. The arrangement would attempt to create a level playing field between a government-administered Medicare and private-sector competitors.

An alternative arrangement—one deliberately designed to erode the popularity of the traditional Medicare program—is to style the choice and competition in Medicare as one between (a) the traditional, unreformed, government-run Medicare program, whose development has been and will continue to be deliberately stunted by the Congress and (b) more modern private-sector insurance products offered by private health plans. It appears to be the style of competition preferred by the President, who would endow the traditional Medicare program with only a skimpy drug benefit[2] and subsidize drug benefits through private plans more heavily, and who would otherwise not alter Medicare's benefit package.

No one, probably not even its proponents, would call the second style of competition *fair*. It is the analogue of a parent offering a high school graduate, as a graduation gift, a choice between (A) a Ford Taurus and (B) a similar Chevrolet, on the condition that the parents will pay for a CD player in the Ford Taurus and pick up the annual maintenance costs on it, but that they will not cover these items for the Chevrolet. It can be doubted that either GM or the kid would call this a fair choice.

What rationale one might offer for styling the competition between Medicare and substitute private health plans in this unfair way.

First, it might be argued that, under our system of political governance and campaign financing, it will always be impossible for Congress to modernize Medicare in step with changes in modern medicine. The argument would be that Congress and successive Administrations have managed Medicare as poorly as they have because, by its very nature and its method of campaign financing, American government manages everything it does poorly. It is a troublesome thought.

Second, it may be argued that government-run health insurance programs are inherently cumbersome, because they must strive to be *horizontally fair* to all parties, while market mechanisms usually are not subject to that constraint, unless government imposes on them. To illustrate, Medicare must observe scrupulously horizontal equity in its dealings with hospitals and physicians. (Horizontal equity means two physicians or hospitals would always be treated the same way). There are public hearings on proposed changes, notices in the *Federal Register*, comment periods, and such. By contrast, private health plans need not be so fair. They can treat different physicians differently, if they can cut different deals with them, and they can change rules or contracts with providers and patients overnight, without much notice, and subject only to the tort system and contract law. Therein lies greater flexibility.

A third argument for the proposed, unfair competition might be that, by their respective natures, private health insurance plans will always be more *efficient* than government-run insurance plans in anything they do. In principle, that hypothesis is amenable to empirical verification, after one has defined carefully what is meant

[2] Medicare beneficiary choosing to stay in the traditional Medicare program would receive free of charge a drug-discount card—presumably administered by a pharmaceutical benefit management company or a private insurance carrier—to benefit from bulk purchasing. They would also have catastrophic coverage for drug spending exceeding an annual threshold, which is left unspecified. Low income beneficiaries would, in addition, receive a $600 annual subsidy toward their drug purchases.

by "efficient." If there is a body of empirical research that convincingly supports this hypothesis (which there might be) I am not aware of it. In any event, if private health plans really are more efficient than is traditional Medicare, why then would they need the boost of a special public subsidy available only to them (and not the traditional Medicare) to be competitive with traditional Medicare?

C. WHAT IS THE GOAL OF MEDICARE REFORM?

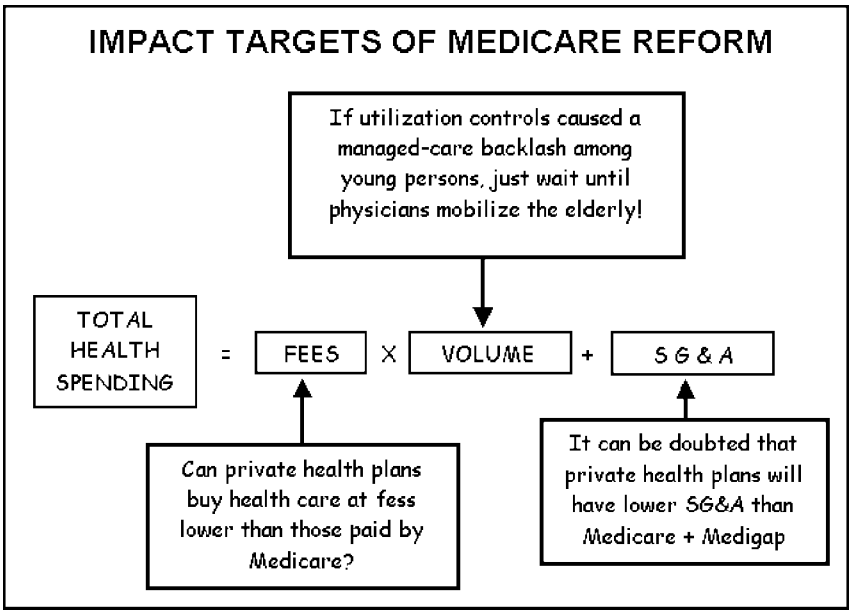
It has never been clear to me just what the goal posited for Medicare reform might be, because usually the authors of such proposals remain silent on the subject. I can think of several distinct goals, to wit:

- **Reduction in total health spending per Medicare beneficiary, from all sources, however it may be split between taxpayers and Medicare beneficiaries.**
- **Reduction only in the taxpayer's exposure to Medicare spending, even if it increased total health spending per Medicare beneficiary.**
- **Obtaining better value for the health care dollar, whatever the source, and whatever Medicare reform does to total health spending per Medicare beneficiary, from whatever source.**
- **Rescuing the private health insurance from a slow death march caused by the ever-finer risk segmentation that occurs under mass customization of private health insurance.**

In what follows I shall briefly explore each goal in turn, referring readers to my Primer for a lengthier exploration.

Goal 1—Reduction in Total Health Spending: If the goal of the proposed Medicare reform were to reduce total health spending per Medicare beneficiary—from all sources, including the beneficiaries themselves—then I doubt that this goal will be achieved with the proposed reform. I come to this conclusion by ruminating on the sketch on the next page.

Given the awesome power traditional Medicare has to set administered prices for Medicare, it can be doubted that private health plans can buy benefits for the beneficiaries at lower prices, or even at the prices Medicare now pays. It may be argued, of course, that these prices are too low, and that private health plans would set more appropriate, higher prices. Whatever the merits of that idea, however, it would drive up total health spending per Medicare beneficiary, not lower it, other things being equal.



It may be argued, next, that private health plans would lower total health spending per beneficiary by "managing" health care utilization (volume) more efficiently

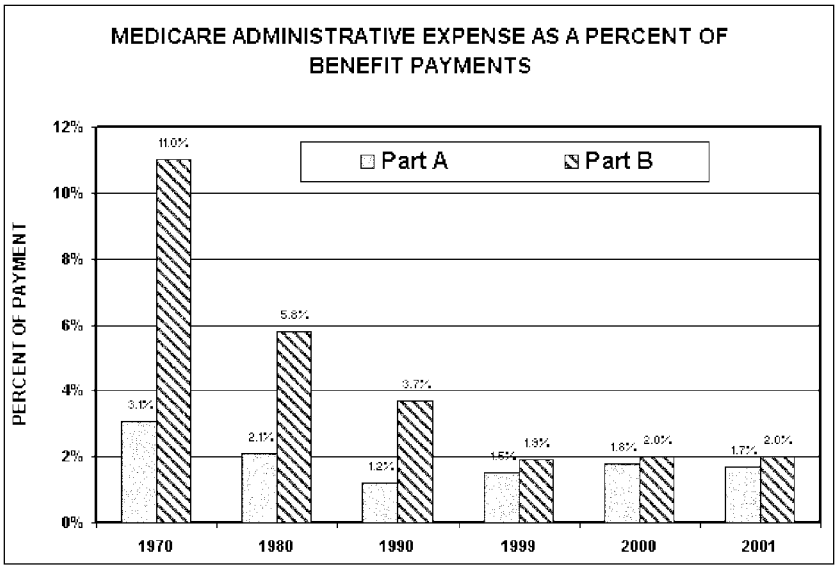
than does traditional Medicare, perhaps through disease management. At the abstract level, this argument has a certain appeal, especially in view of the previously cited Wennberg variations. But there are practical obstacles to this strategy.

First, if attempts by private health plans to "manage" the utilization of health care by employees triggered a "managed care" backlash in the younger generations, one can only imagine what backlash that attempt would trigger among Medicare beneficiaries and their physicians, if these much maligned (though theoretically defensible) managed-care techniques were applied to the elderly population.

Second, there is scant empirical evidence that the private health plans so far have performed much disease management. One would have thought that these plans should have been able to earn a fortune by managing health care properly in counties where their premiums were based on 95% of a very high *Average Actuarial Per Capita Cost (AAPCC)*—e.g., Dade County Miami, Baton Rouge, Louisiana, and so on. Yet when Congress capped the premiums paid the plans for the high cost countries under the Balance Budget Acts of 1997 (BBA 97) at an annual growth of 2%, the plans professed not to be able to manage with those premiums. Evidently, there are narrow limits to the plans ability to reduce utilization even in high-utilization areas.

Third, the concept of *Enhanced Medicare* proposed by the President envisages health insurance products otherwise known as Preferred Provider organizations (PPOs), which resemble nothing so much as open-ended, unmanaged indemnity products. Such open-ended plans are unlikely to control volume significantly better (if at all) than traditional Medicare does now.

Finally, it is doubtful that the total fraction of the premium that plans need for marketing, administration and profits (SG&A plus profits) under a privatized Medicare program will be lower than the sum of the administrative cost of traditional Medicare (less than 2% of expenditures, see graph below) plus those of Medigap policies.



Source: CMS, http://cms.hhs.gov/charts/default.asp, CMS Facts & Figures, II. CM Program Operations, June 2002 Edition, Slide II.6.

In sum, if, relative to traditional Medicare, private health plans would be unlikely to achieve (1) lower prices, (2) significantly lower volume or (3) lower SG&A costs, whence then would come any cost savings from privatizing Medicare?

Goal 2—Limiting the Taxpayer's Exposure to Medicare: If the goal of Medicare reform were merely to limit the taxpayer's contribution to the health-care cost of Medicare beneficiaries (even if that drove up total health spending on them from all sources) that goal could be achieved with such a reform, at least theoretically.

In effect, the reform would be designed to convert the Medicare program from its traditional structure of a *defined benefit* program (which saddles taxpayers with the

risk of health care cost inflation) to a *defined contribution* program (which would shift the risk of future health-care cost inflation substantially onto the shoulders of Medicare beneficiaries). It would, in effect, represent a reallocation of an essentially uncontrollable fiscal burden from the young to the old.

In view of the burden of the retiring Baby Boom and the inexorable decline in the number of workers per elderly in the decades ahead, such a strategy certainly deserves careful consideration. If that be the goal of Medicare reform, however, one would hope that those positing it would do so straightforwardly, for open debate in our democracy.

Goal 3—Obtaining Better Value for the Dollar: It may be argued that private health plans can obtain better value for the Medicare dollar (regardless what total health spending on Medicare beneficiaries may be), because these plans know how to manage health care better than does traditional Medicare.

Although that proposition has appeal, there is the caveat that any such attempt at "managed care" might trigger the backlash alluded to above. Indeed, the President's proposed Enhanced Medicare is explicitly designed to spare Medicare beneficiaries these "managed care" techniques.

Furthermore, there is no reason why traditional Medicare could not be allowed to purchase health care more prudently than it is now allowed to do and to engage in modern disease management. Government-run or -controlled health insurance programs abroad—e.g. in Germany—certainly are now experimenting with this approach. If Congress wished to attain better value for the health care dollar under traditional Medicare, it could certainly achieve that goal.

If, on the other hand, Congress as a matter of *fiat* steadfastly refuses ever to allow traditional Medicare to manage itself and the care it procures more efficiently, then almost by definition and by deliberate design private health plans will have a comparative advantage in this regard. In that case, however, it would seem reasonable to ask Congress for an explicit justification of such a policy.

Goal 4—Rescuing the Private Insurance Industry from Self-Afflicted Demise: In my *Primer* for journalists, I explore at greater length the effect that the ever-finer risk segmentation within the private health insurance sector will have on the fraction of the health care dollar that the private sector will control in the future.

Although the sector currently covers two thirds of the American population, it accounts for only about one third of total national health spending. It is so, because fiscal responsibility for the more costly citizens—the blind and disabled and the elderly—has been left to the public sector.

If the private insurance industry continues to segment risks as it has in recent years—through ever more sophisticated "mass customization" of its policies—then more and more chronically ill Americans will be flushed out of its book of business and onto the mercy of government. Thus, a decade hence the private sector might control only 25% of total health spending.

One could think of the proposed Medicare reform as a strategy designed mainly to rescue the private insurance industry from this self-inflicted wound. It would be a purely political decision, of course, that one would be hard put to justify on economic grounds.

D. OBSTACLES TO MEDICARE REFORM

Among the potential obstacles facing the proposed reform of the Medicare program, and listed in my *Primer* for journalists, are the following:

1. Competitive Bidding: Competitively bid premiums are the central core of most proposals to privatize Medicare, the President's included. Competitively bid premiums are thought to be the main engine for quality and cost control. Yet, as noted earlier, previous attempts by Medicare to experiment with competitive bidding by private health plans has met with stiff resistance from the health plans. They have invariably been killed, courtesy of the good offices of the Congress. What assurance do the proponents of Medicare reform have that the plans would embrace the competitive bidding envisaged by the proposal?

2. Risk Adjustments: Any system of competitive enrollment of diverse people by price-competitive private health insurance plans requires that the premiums paid the plans be adjusted for the actuarial risk of the enrollees choosing the plans. Unfortunately, no one in the world has yet developed a satisfactory risk-adjustment instrument for this purpose. The risk adjuster currently used by Medicare for its *Medicare+Choice* program, although fairly sophisticated by international standards, has been vehemently criticized by the health plans. Concretely, then, what ideas for risk adjustment do the advocates of the proposed reforms have?

3. Wennberg Variations: There is the question how a reformed Medicare would cope with the previously cited Wennberg variations in Medicare spending. These

variations have hitherto been politically acceptable, because they are known only to the *cognoscenti*. The proposed reform might flush them out to greater visibility and trigger political controversy.

4. Insurer of Last Resort: Finally, there is the question how any competition between traditional Medicare and private health plans can ever be on a fully level playing field, if the private health plans are permitted to withdraw from certain regions of the country in which they cannot thrive, while traditional Medicare must stay as insurer of last resort. That facet of the proposed reform required further thought than it has hitherto been given.

Mr. MCCRERY. Thank you, Dr. Reinhardt, and thank all of you for your testimony. I am going to turn, first, to the Chairman of the Subcommittee on Health, Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. Thank you all for your thoughts and your very thoughtful testimony.

Dr. Reinhardt, under program shortcomings, you mentioned prescription drugs, no stop loss and cost-sharing issues, but you don't mention almost total lack of preventive, coverage of preventive benefits under Medicare, and more importantly, Medicare has no capability to provide management of chronic illness. Structurally, it doesn't have that capability, and yet about 32 percent of the seniors that have 5 or more chronic illnesses are using 78 percent of the resources.

So, when you say what could plans offer us, the private sector is far more advanced than is the public sector in managing care, not managing care in the old HMO model; managing care in the integrated disease protocols models.

When you look at the number of people retiring and the length of time they are living, and the number of multiple diseases they are living with, do you think that there is no opportunity to save money in Medicare by better managing chronic disease?

Dr. REINHARDT. Oh, no, I do believe—that is on page 10, my goal 3. I said it could be that we assume we get better value for the dollar, in particular, disease management, which is also I mentioned in the——

Mrs. JOHNSON OF CONNECTICUT. It is very much of an aside, and, to me, if 32 percent are using 78 percent of your resources, and that type of patient is going to grow, this is not an aside.

If we want to bend long-term spending in Medicare, we can do exactly what has happened in other sectors of our economy. Through more integrated teamwork, through better use of technology, we have reduced costs and improved quality, and that is really what disease management does. It improves the quality of care for the individual patient, but it reduces the overall cost by reducing hospitalizations, emergency room visits, and in many instances even physician visits.

If this were aggressively pursued in the near term, with CMS identifying these patients and giving them incentives to join such plans, the issue really isn't would this save money, in my mind; the issue is how do you do it? How do you let both private-sector plans that have demonstrated that they are doing this well do this for our seniors, and how do you provide access to coordination of care,

management of diabetes, management of heart disease, these kinds of things in rural areas where there is no plan?

There almost invariably is some small hospital or medical practice that, with the resources, particularly the technology, could do this. This is springing up from the medical community, and it is better quality and lower cost.

So, your analysis is interesting, but it is too focused on where we are now and the way we have always viewed care. If we are going to view care more holistically and more proactively, we will get higher-quality care, and we will be able to, in the long run, keep people out of dialysis. That will save us money.

Dr. REINHARDT. Yes, Congresswoman Johnson, I agree there is some experiment or some initial experiments with disease management, but I think it would not be accurate to say that disease management is now widely practiced in the private sector. They, too, are only just beginning, and usually the mechanism they use is to contract/subcontract with specialized niche companies who do that.

There is no reason the traditional Medicare couldn't do that, too. It could deal with Centers of Excellence, it could do selective contracting. It could do almost all of it that a health plan can do. The real issue is it needs the authority from the Congress to do it.

I think you might want to invite people like Marilyn Moon, who have thought much about this, who would tell you, you don't necessarily have to join a private health plan to get disease management.

Mrs. JOHNSON OF CONNECTICUT. My time is about to expire, and I want to see if anyone else has a comment. I agree with that, but I don't think you want to exclude those systems that have more advanced capability than we do. I think you need to do both.

Dr. REINHARDT. Not at all. In fact, I say I welcome always competition. Every public program, where feasible, should have competition from the private sector, whether it is Federal Express and the U.S. Post Office or health plans and Medicare. I totally agree with you on that.

Mrs. JOHNSON OF CONNECTICUT. Dr. Pauly and Dr. Stuart. Do you have any comment?

Dr. STUART. I am sorry?

Mrs. JOHNSON OF CONNECTICUT. Do either of you have any comment on this aspect of cost control and Medicare?

Dr. STUART. I was going to say that I have trouble hearing, and so if I ask you to repeat your question. I also might note that Medicare does not cover hearing aids.

[Laughter.]

Dr. STUART. Let me make a point about disease management. Disease management, actually, as it is practiced by these niche companies, typically plays a heavy role in terms of prescription drug therapy. So, it would be very, very difficult for Medicare, as it is currently constructed, to encourage disease management, because one of the central elements of disease management in the private sector is simply not available to Medicare. So, I think that simply making prescription drugs available would actually make it feasible to develop disease management approaches.

Dr. PAULY. Well, I am both more and less optimistic than Professor Reinhardt. I think if we judge from the competition between

managed care and fee-for-service in the private sector, although we don't have any definitive estimates, my entry in the office pool is that managed care saved about 15 percent. Now, that was a one-time saving, but it was what resulted in very low rates of growth for private sector spending from about 1994 to 2000. You might be able to see that same sort of saving within Medicare, but it would require what managed care required in the private sector, which is limitation, greater limitations on patients and providers, and that would fly in the face of what people love about today's Medicare. I will say though I am, in 4 years, contemplating being eligible for Medicare, and one of the things I worry about is a point that Chairman Thomas made this morning. I worry about the relevant comparator, you need to have the relevant comparator. My judgment is today's Medicare is not sustainable. I am not sure whether it is sustainable for the next 4 years, but is certainly not for as long as I hope to be around and a burden on my children. So, I think the affection that people feel for a very generous program, of whose cost they pay less than 10 percent, is not something that we can continue to hold out for future generations of elderly people, so we need to think about how to change that.

The good news is that some private sector plans may be able to save money, although they will probably require some restrictions that Medicare beneficiaries are not used to. The bad news is that potentially the savings that private sector plans can achieve, which in part result from obtaining lower prices and discounts to providers, Medicare may have already achieved. So, at least the part about better negotiation with providers, at least to judge from the complaints of hospitals and physicians these days, Medicare may have already made those cuts, so there may not be as much of a gain.

In keeping with the tradition of economists as professional wet blankets, I guess what I see as the main advantage of competition in Medicare is that when the inevitable restrictions come, I would rather have a choice of how to have those restrictions imposed on me, rather than have them decided unilaterally and in a monopolistic way.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Dr. PAULY. It is a kind of name your poison phenomenon.

Mrs. JOHNSON OF CONNECTICUT. Thank you. My time has well expired. Sorry.

Mr. MCCRERY. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I am confused about what it is we are trying to hear today. I wanted to ask Dr. Reinhardt some questions, but I would ask Dr. Pauly, if he would be so good—he mentions the research about lowering the copayment produces a 65-percent increase, and if you could at some point after the hearing or subsequently just give me a reference to that, I would be interested in looking into that further.

I wanted to get to why we are talking about Medicare reform, as in quotation marks, and that is, what are we trying to do? I am going to ask Dr. Reinhardt to give me what my choices are, and also to comment on this often stated theory that competition and free enterprise are what is missing in controlling the delivery of health care, medical care, to particularly seniors. For one thing, I

am confused when people talk about choice in prescriptions. I don't know if anybody in this room, including some of the physicians, could tell me what half the prescription drugs that are advertised in People Magazine do for you or to you. I am sure that none of us are apt to go off and buy some just for the hell of it if we don't know what is going to drop off or quit working if we take this stuff. I don't know any of us that know the cost of any of these tests. I have often stated that if I offered witnesses a half-price proctological examination at George Washington this afternoon, would you run up and take it? No, you wouldn't. Only if your doctor told you to you might.

So, what is this market based on? I went to a school where they taught marketing, and they had some economists there and they talked about having to have a knowledge of the market and how do consumers decide if they don't know what the hell they are buying?

So, I wonder, Dr. Reinhardt, if you could elaborate for us a little bit about what—accepting your challenge that we have to fix it, what in broad terms are our options in fixing it, which is to provide a proper amount of medical care to all Americans, and what factors would help us most, free market, complete competitive bidding? Go ahead.

Dr. REINHARDT. Well, starting with the latter, the competitive bidding, California Public Employees Retirement System, which is the biggest purchaser of health care in California, your State, last year had 25-percent premium increase. These were highly competitive plans, and the question of course you have to ask yourself in Congress, is that the kind of cost control that we can afford; is that sustainable, or how do you make this sustainable? I think your only option is to roll that responsibility over on the elderly, which maybe should be done, but I think that should be openly discussed to what extent that is the goal of Medicare reform.

I think whenever you hear people say the people should have more "skin in the game," as the language is, fiscal skin in the game, what is actually really being talked about though—and again, maybe that should be done—you want to ration health care by price and ability to pay, and it is the lower half of the income distribution who should carry the burden because think of someone in the top first or second percentile of the income distribution, someone making more than $200,000. What does it actually mean for them? I'm in that position. Cost sharing doesn't mean a thing to me. Whatever it is, I'll pay it. So, it has zero effect on people like me, but if you were a gas station attendant, cost sharing has a major effect. So, we are saying like food is rationed and like housing and clothes, we would like to ration health care. That way the burden would mainly be borne by the lower half of the income distribution.

There is no reason why a nation might not choose that as long as you are honest about it, that is what markets—or cost sharing, that is what it really achieves. I am not—I think I am more inclined, as Mark says, to have some choice as always, because most airlines are the same, lousy food, lousy planes, but it does give you some pleasure to be able to tell one airline to go to hell. I have often done it, just the last minute I have rebooked, and I think that

is sort of what Mark—pick your own poison, so to speak. There is some virtue in that, and that is why some competition is obviously very good. When the President talks about enhancement Medicare, which is essentially PPOs, which is essentially warmed-over fee-for-service, unmanaged. I cannot imagine where the savings would come from, other than this ability, Mark says, to have some choice is always a good thing.

Again, I want to emphasize I am not at all against it; I am for it. I would worry about having a popular program such as Medicare—which is not more expensive, as Marilyn Moon's research shows—abolished simply because some people don't like the esthetics of it.

Mr. STARK. Thank you.

Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Mr. McDermott.

Mr. MCDERMOTT. Dr. Reinhardt, knowing the injunction about not casting pearls before swine—there are very few of us left—but I would like to give you a Blue Book question. If a country can for 120 years provide a guaranteed set of benefits, including prescription drugs, as Germany has done, what is it that is wrong with Medicare that—or what do we need to change in Medicare to make the same thing possible for the elderly in this country?

Dr. REINHARDT. Well, you would need to modernize the benefit package. It is sometimes overlooked that until 1990, Medicare was the more innovative program that kept step. Medicare covered renal dialysis when it was technically feasible. Medicare introduced diagnosis related groups. Medicare introduced the fee schedule. It was only after 1990, when the private plans introduced prescription drugs, that Medicare fell behind. Those plans also didn't cover preventive care until about 1992. So, when you talk about modernizing, mainly it is that you have to have a modern benefit package.

What makes Germany cheap are two things. One, simplicity. It is a very simple program. It has very low administration. There was a McKinsey Global Institute study that showed in 1990 Americans actually got $390 less health care—doctor visits, pills, and so forth. So, we were clinically more efficient, they said, because we spent less. Ninety percent of that was spent on administration.

I am on the board of the Duke University health system. We consolidated our billing, and I was told we have 900 people in the billing department. I got kind of angry, and I said, well, is that Medicare—Medicare compliance? The answer, no. For the most part it is because we have 60 different plans, each with their own rules, they don't pay. Medicare pays within 20 days, it is electronic. Private is still all paper.

So, Germans save a lot of money on administration by having standard billing forms, standard fee schedules, and those kind of things; where here there are no fee schedules. We have a market without prices. I defy anyone to give me the website in Washington, DC where I could find out what different physicians cost. Each fee schedule has 9,000 items in it. How would you technically even do this? You need somebody to negotiate these things for you. I think that is, of course, Medicare's advantage. It is a simple program. Prices could be negotiated, too. You set them, but they could

be negotiated, the way Germans do it, and make the program a lot simpler.

There is no question, Germany's population today is as old as ours will be only in the year 2020. Yet Germany's spending per capita is about 57 percent of ours. There is no discernable difference in health status.

Mr. MCDERMOTT. What is their mechanism by which they control the pharmaceutical industry? The pharmaceutical industry is as big in Germany as it is in this country, I think, on some relative scale. How did they deal with the cost of pharmaceuticals?

Dr. REINHARDT. They use what I think both Professor Pauly and I would call a market approach called reference pricing, where they classify groups into therapeutically equivalent classes of drugs, reimburse fully—not the cheapest, but sort of the third way up drug—and then tell the patient if you want a more expensive drug, you have to pay the whole difference between that benchmark, the reference price, and that brand-name price, out of pocket. That has really worked, substantially, in Germany.

In addition, though, they also put a budget on top of drug spending. Reference pricing is very much hated by the pharmaceutical industry, because in Germany the prices of brand names tended to collapse to the reference price. The pharmaceutical industry then fears that there won't be enough of a margin for innovation. That has been the argument.

Mr. MCDERMOTT. Do you agree to that, that if we put reference pricing in our system, suddenly there would be not enough money in the system for innovation?

Dr. REINHARDT. I think what you need to do to build those groups is to have absolutely first-rate science to make sure that really better drugs actually don't get penalized, that it is only the me-too drugs that you push down. That is where there might be some controversy.

I think as a general rule, if you take money away from the pharmaceutical industry, every item in their income will probably go down. They are spending 13 percent of revenue goes for research and development (R&D). If you took a buck away, there might be maybe 13 cents of R&D might disappear. Marketing would disappear, too, and other things as well. When you take a dollar away from a drug company, I don't think Mark and I would say you lose a dollar R&D. That is not true.

Mr. MCDERMOTT. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Mr. Becerra.

Mr. BECERRA. Thank you, Madam Chair. Thank you to the three of you for your testimony. If I can, I would like to just follow up on a couple of things that Dr. Reinhardt mentioned earlier.

First, Dr. Reinhardt, you mentioned that Congress as the board of directors, as you said, could, if it chose, address some of the concerns that we have with the current system of Medicare. Let me ask you this—and I would pose this to the three of you. Should we, if we end up with a privatized system of health care for our seniors, whether it is for prescription drugs or general for Medicare, should we require attributes all providers, private insurers, in the case of a private plan, be required to offer a plan in all geographic parts of the country? Which is something that, I think, Dr.

Reinhardt, you mentioned that Medicare doesn't have a choice in Iowa or anywhere else, it has to offer to that senior. Should we impose that as a requirement on any private insurer if we go toward a privatized system of Medicare?

Dr. PAULY. No, I don't think so. I think some insurers, the Blue Cross insurers, although it is changing, wouldn't be capable of offering something country-wide. I think it would do a lot of violence to the current structure of insurance markets.

Mr. BECERRA. Who would then cover——

Dr. PAULY. Let me say what I think, what——

Mr. BECERRA. Dr. Pauly, if I could ask you, who would then cover, if it wouldn't be Blue Cross or any other private insurer——

Dr. PAULY. Well, it doesn't have to be every insurer in every location. If—and this is the next point I wanted to make—if insurers are not willing to enter Iowa or wherever, or Ohio, where I came from, or Pennsylvania, where I am now, that is a sign that the current payment rates are inadequate. The solution to that is not to force them to enter areas where they are sure to lose money. Even if you are able to be effective, they will de-market their services and provide very poor service. The solution is to adjust the payment rates so that it is equally profitable, at least as much as you can approximate it, for insurers to enter in all parts of the country. That will surely mean, as we heard some discussion this morning, paying more in some areas than others because in rural areas you can't have the same kind of economies of scale as you can have in urban areas, but on the other hand, you are not paying big-city prices, either.

Mr. BECERRA. That doesn't seem to reduce the cost overall of Medicare if we are having to increase the costs that we pay in certain parts of the country to encourage the private sector to go into those areas that Medicare currently services.

Dr. PAULY. No, I think this would be an attempt to be more equitable and even-handed in providing access.

Mr. BECERRA. It would increase costs?

Dr. PAULY. I am not sure it would increase costs. That depends——

Mr. BECERRA. Well, if it doesn't increase costs, why can't we keep the level of reimbursement as it is, what Medicare currently is receiving, or what we are providing it to offer these services?

Dr. PAULY. You would lower it in some places and raise it in others if you thought access was currently unequal.

Mr. BECERRA. I see. I see. I don't know, Dr. Stuart, if you wish to add anything to that?

Dr. STUART. No.

Mr. BECERRA. A question with regard to what Dr. Reinhardt said in terms of the total health care spending and how you come up with that calculation, the fees times the volume plus your costs. Do any of the other panelists disagree with what Dr. Reinhardt has identified as the variables, the factors that we would take into consideration, that formula for determining overall costs? Dr. Stuart or Dr. Pauly? Any disagreement? I don't want you to go into it, just to—I wonder if you agree or disagree.

Dr. STUART. Well, I think it is an accounting framework, and the elements of the accounts are there. So, one might disagree in

terms of where savings might be obtained in one of the elements as opposed to another element. I think, certainly, the model itself is complete.

Mr. BECERRA. Can anyone identify for me a private insurer which today administrative costs that are lower than what Medicare spends? There, Medicare doesn't market, so it doesn't have marketing expenses. It also doesn't seek to secure a profit. So, if we could factor in marketing and profit into that cost of administration, can anyone name for me a private insurer that right now offers a health plan and benefits for a lower administrative cost as I have defined it than does Medicare?

Dr. PAULY. Well, the literature says—actually, it doesn't identify private insurers by name, but the traditional estimates in the literature on group insurance are that large group insurance, say the General Motors-type firm, would have administrative costs of around 5 percent.

Mr. BECERRA. That is still higher than Medicare.

Dr. PAULY. It is still higher than Medicare, but the difference, as you mentioned is that Medicare raises its money via compulsory taxes and private insurers don't have that luxury or that privilege. To my understanding, the pure cost of claims processing is not terribly different between Medicare and private insurers. The primary difference, the thing that explains why Medicare is at 3 percent and private insurance on average is at around 13 percent, are those selling costs. You have to talk people into private insurance. You don't have to talk them into Medicare because it is 10 percent subsidized—only paying 10 percent of the price, and also billing costs. When people buy private insurance, somebody has to remind them to pay their bill every year.

So, there are a lot of good things to say about Medicare, but I actually think the administrative cost saving is somewhat of a red herring. If you compared kind of equivalent costs for doing equivalent things, the people up on Security Boulevard are wonderful people, but I don't think they are any better or worse than the private sector.

Mr. BECERRA. I think that is a very good point in terms of the marketing, that as a mandated program you don't have marketing costs, you don't have to try to go out there and solicit business. Dr. Stuart, did you want——

Dr. STUART. I think there are a couple of other elements here on, actually, both sides of the argument. One of the arguments behind the difference in measuring administrative costs in a public program and a private program is that although what you count as an administrative cost in a private program might show up in terms of higher prices or in terms of inefficiencies in the public program. So, you have to be careful when you are just looking at that stratum that goes to administration on the balance sheet, or on the income statement.

The other thing that I might note is that the administrative costs under Medicare are managed. Those costs are determined by budgets. You determine how much Medicare spends on administration by how much you are willing to give CMS to carry out its mandate.

Mr. BECERRA. My time has expired. I would just like to make sure that—I didn't hear anybody mention a particular private plan

in place that offers its services for a lower administrative cost than does Medicare. I think the point is well taken, though, in terms of marketing. There may be some value in having a mandated system which doesn't require marketing nor the profit element in terms of costs that ultimately seniors have to absorb in order to be provided with a health care benefit.

I thank you very much, and thank you, Madam Chairman.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Before I recognize the next speaker, I would like to point out that Medicare's administrative costs do not include Treasury's costs of collecting the Medicare tax nor the inspector general's cost of their portion of overseeing Medicare with the fraud and abuse function, which the private sector covers.

In addition, I don't know, and I will ask the experts, has anyone ever done any study of the combined administrative costs by the government and the administrative costs that the payor pays on the provider? For instance, Medicare imposes much heavier costs on home care providers than private sector providers impose on home care providers. That is one of the reasons why I am trying to eliminate the Outcomes Assessment Information System form for private-care patients. So, has there been any combined look at administrative costs of both the government and those on its providers that it has imposed, versus the private sector's administrative costs and the administrative costs that they impose on providers?

Dr. REINHARDT. I think that is a good point and worth a study. There are compliance costs with Medicare, particularly when you have a corporate integrity agreement, which is one of those letters that oblige you to be audited and so on. What struck me in the Duke example—and I have asked in the other company on whose board I am, too—the unbelievable back-and-forth to get a claim paid, that goes back several times.

Mrs. JOHNSON OF CONNECTICUT. In Medicare, you mean?

Dr. REINHARDT. In the private plan, where your payment days outstanding may be 90 or 100 days. So, if you take Duke, for example, we have a float of $250 million a year that has to be financed. I asked, well, why aren't we getting paid? They told me, well, Medicare is not the problem; we get paid in 20 days.

Mrs. JOHNSON OF CONNECTICUT. Dr. Reinhardt, if I may interrupt you, if you have ever been to a doctor trying to get paid for comprehensive physical versus a detailed physical with very different payment rates, you can see exactly this long paper trail. I have one hospital that has an intensivist overseeing their intensive care unit. It is saving Medicare money. We have a code for this and never, ever have they been able to get paid under the Code. They just provide more and more documentation.

So, frankly, I am loaded with examples of that kind of problem going on over months or years. At one point, Medicare stopped paying for all partial hospitalizations in my State and it took us 9 months to straighten it out. So, I would have to have a study show me that there were more serious payment controversies in the private sector than those in the public sector.

Dr. REINHARDT. Well, as I said, it really would be worth studying.

Mrs. JOHNSON OF CONNECTICUT. It would be worth it.

Dr. REINHARDT. I would include an administrative cost on the private side; also, of course, the claims processing. I don't do it. I just refuse. My wife does it. She tells me that her claims processing is worse than doing the income tax. She does the income tax, too. So, we have a good apple-to-apple. She says dealing with the insurance is a lot worse.

Mrs. JOHNSON OF CONNECTICUT. On the other hand, having just broken my ankle about a year ago and being a Medicare recipient, I can tell you the number of mailings that I received for a simple broken ankle was scandalous, from Medicare, scandalous. So, I do think we should try to find that, and any of you—and let me let the others comment and then we will let the other two Members question before we have to go. So, briefly.

Dr. PAULY. Just two comments. First, there are estimates of the administrative cost at hospitals for third-party payment and they run around 20 percent. So, they are certainly not trivial. I haven't ever seen any Medicare versus private sector. Of course, if it is hopeless to try to get money out of Medicare, there is no point in a doctor wasting administrative costs.

Mrs. JOHNSON OF CONNECTICUT. We do have only 13 minutes left, and I have two questioners——

Dr. PAULY. Some physicians feel that way. The other point I wanted to make, though, I think an important, often neglected to mention, administrative cost to the Medicare system is, well, the slogan is one-size-fits-all. I don't much like that sloganeering, but people buy Medigap coverage to tailor Medicare to their own desires. So, really, the administrative costs of Medigap plans ought to be attributed to Medicare. If you did that, you would end up with a lot more than 3 percent.

Mrs. JOHNSON OF CONNECTICUT. A very valid point. I am sorry, Dr. Stuart, since we only have 15——

Dr. STUART. Let me just take 1 minute to suggest an area in which administrative costs are going to be a major concern for Congress as it considers the Medicare drug benefit, and that is the administrative costs that are imposed on the private sector by private plans developing wildly different formularies. I can tell you that this is very costly to medical practices, because the physicians can't figure out which patients are covered under which plan and which drugs they should get. It is particularly costly on pharmacies because the patient comes in and the drug is not covered under the formulary——

Mrs. JOHNSON OF CONNECTICUT. That is a very important consideration. We may get back to you on that. Mr. Pomeroy.

Mr. POMEROY. My time is very brief, but I want to ensure my colleague, Ms. Tubbs Jones, also has time. So, I think that I will pull back out of the weeds a little bit of how we restructure Medicare. I will note consensus across the panel that some work is needed here, even though there may be substantial difference in terms of how we proceed.

The thing that I am wondering about is regardless of what we have by way of exact delivery of benefit mechanism under the name of Medicare, how we pay for it in the next decade if we don't do some preparatory work this decade to strengthen the financial

position of our country to prepare for the entitlement hit of baby boomers. It would seem to me specifically that paying down the debt this decade would make more sense than adding to it significantly, because I believe borrowing in the next decade will absolutely be essential to cash flow the requirements that we see in the Medicare trust fund.

If we could run across the panel and give us your counsel on that one. Would it be better to increase the debt or decrease the debt for purposes of preparing to meet the entitlement challenge of baby boomers, or is it your position that we should simply back off of those entitlement commitments. Dr. Reinhardt?

Dr. REINHARDT. Well, I would have been in favor of not increasing the deficit, actually try as much as possible to have a surplus and buy back the debt. That is really supply side economics. How would that work? You could imagine the Medicare trust fund just buying through the Treasury, buying back bonds. Those bonds would be owned by pension funds. They would have to recycle that money into the private sector. That is the clearest way to get 100 percent of that money into investment. If you instead give it in tax cuts to individuals, like myself, who benefits from these tax cuts, I might buy a new Mercedes—in fact, I have—with the money and it might not yield productivity.

So, I believe going the route of having less of a deficit. Once the day will come when Europeans may not wish to hold dollars or other nations, they may wish to hold euros. That seems already to be happening. It could be happening throughout the Middle East. You will see interest rates skyrocket in the United States.

So, I think the fiscal policy we are now on, to my mind is not the right path.

Dr. PAULY. Well, I would risk controversy by saying I prefer a smaller debt to a larger debt. I don't think that is the most important thing that will determine the future viability of the Medicare and other entitlement programs. I think it is the overall economic health of the economy, so that the rate of growth of gross national product (GNP) and the level of real GNP is a lot more important than the level of debt. Other things equal, lower debt is better than larger debt, but if the economy can be made to operate better, that is going to be much more important. That is the first thing I would do to save Medicare.

Mr. POMEROY. Significantly higher debt could even interfere, perhaps, with some of the economic——

Dr. PAULY. Well, it is the ratio of debt to GNP that you ought to pay attention to, not the absolute level of debt. I would rather work on the GNP side than——

Mr. POMEROY. I accept that, but for the known fiscal hit we all know about—lives in being with existing entitlement commitments—that it seems to me should also be factored in, unless we are straight-up talking about diminishing those entitlement commitments.

Dr. PAULY. Well, I personally think we ought to start talking about diminishing those entitlement commitments because, given the demographics, I don't see any way to avoid that. I guess that is the other solution—this is only my own personal solution—have more grandchildren. That would help a lot.

Mr. POMEROY. Thank you. Thank you very much, Dr. Pauly.

Dr. STUART. Well, I will make it three in terms of reducing the debt. I happen to believe that the absolute level of the debt is important as well as the relative level of the debt, and I am concerned to see the debt rising as fast as it is.

I do think, however, that when one makes decisions about Medicare, it is going to be very difficult, if not impossible, to make a decision about the entire program. I really believe that is true. So, what that means is that you are going to have to deal with incremental changes within that program. So, when we, each of us received the invitation to talk today about modernization in Medicare with a prescription drug benefit, I think the prescription drug benefit should be treated on its own merits. What you really need to do is you need to say is this something a modern Medicare program should have—and I believe you will say yes—and then the question is how best to do it.

Mrs. JOHNSON OF CONNECTICUT. All but 8 seconds of the gentleman's time has expired, so if we may move on to Ms. Tubbs Jones. We have 5 minutes before the vote.

Ms. TUBBS JONES. Five minutes?

Mrs. JOHNSON OF CONNECTICUT. Five minutes. You can take 4 minutes.

Ms. TUBBS JONES. I won't take that long, probably. Dr. Pauly, you say you are from Ohio. Where?

Dr. PAULY. Cincinnati.

Ms. TUBBS JONES. Cincinnati, oh, the other end of the State. They say it is like Cleveland and Cincinnati are in two different States. All joking aside, one of the biggest problems we have had with health care in Ohio is the fact that the private insurers have not been required to contract, that they could just give notice and say "I'm gone" and in 30 days the people having health care under the HMOs in Ohio have just run away. So, then we end up with people with no health care coverage. That is why I have a real dilemma with pushing Medicare into the HMOs, based on the experience that my Medicaid constituents have had with the HMOs.

Real short: How do I resolve that problem? If I agree I want to go with private insurers, how do I resolve the running away from my constituents?

Dr. PAULY. Well, you have to pay them enough to make it worth their while to stay.

Ms. TUBBS JONES. Except when they enter into the contract, they know what I am going to pay them.

Dr. PAULY. Presumably, they run away when the contract is expired, not before.

Ms. TUBBS JONES. Well, we have had it as terrible as 30 days. I am not going to argue that. That is my dilemma with the private insurers.

Dr. PAULY. Then I would say write more iron-clad contracts. The fundamental aspect of private firms is that they need to be able to cover their costs in order to remain in business.

Ms. TUBBS JONES. Dr. Reinhardt, how do I resolve this issue as we reform Medicare?

Dr. REINHARDT. Well, one is to pay more. Then Congress, of course, loses any sense of budgetary control, have even less than

they have now. Or the alternative is to make sure the old Medicare is always there as a fallback position, which would be my—my favoring that program is because it is a fallback position.

Ms. TUBBS JONES. Why do we always have to worry about deficit spending when it comes to programs such as Medicare and Medicaid, and we don't ever worry about deficit spending when it comes to things like military spending and the other issues? I voted for the Supplemental, and I support the military. I am just wondering why that number always comes up. Dr. Pauly?

Dr. PAULY. Well, I don't worry about deficit spending for Medicaid, at least the part of it that pays for children, because I view you are making an investment in children and that is as good as an investment in national security. I think for senior citizens, in a way, it is more difficult because it is less easy to make the argument that the spending will yield returns.

Ms. TUBBS JONES. If I was sitting at the table and I had to decide whether you got services, and you would live or not live, you would want me to let you live, wouldn't you? Or give you the treatment that was necessary for you to hang around for a little while?

Dr. PAULY. Well, certainly, but those are presumably not the services that we are talking about rationing or not rationing.

Ms. TUBBS JONES. In your prior testimony, you alluded to it. I am going to end my time, Madam Chairman. Thank you, gentlemen, for giving us this opportunity.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much for being here. I appreciate it very much. I do hope we will get a chance to pursue this conversation later on as the bill develops. Thank you.

[Whereupon, at 2:41 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Cori E. Uccello, and John M. Bertko, American Academy of Actuaries

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to expanding coverage of prescription drugs in Medicare. The Academy is the non-partisan public policy organization for actuaries of all specialties in the United States.

This statement focuses on three areas that Congress needs to address as it designs a Medicare prescription drug benefit:

- First, if enrollment in the drug program is voluntary, the program must be designed to minimize adverse selection. That is, actual program enrollment needs to be nearly universal, broad enough to include healthy participants as well as those who would be expected to be high utilizers of the program. Otherwise, per-enrollee costs could become too high, potentially leading to the need for increased beneficiary premium contributions and cost sharing, and discouraging the participation of private entities that administer and/or deliver the benefit.
- Second, the plan must include components that will help minimize per script costs, contain drug utilization, and keep total spending to an affordable level. Otherwise, drug spending under the program will grow much faster than projected, further endangering the solvency of the overall Medicare program.
- Finally, policymakers may want to add risk-sharing provisions during the first few years after implementation to private sector organizations administering or delivering the benefit. Risk-sharing provisions are especially important in the early years of the program, until pent-up demand levels off and utilization data for previously uninsured beneficiaries becomes available.

These issues are discussed in more detail below, along with options for addressing them.

Adverse Selection

Adverse selection can be a problem in any voluntary health insurance program. Because people in poor health are more likely to purchase coverage, and to purchase more generous coverage in particular, premiums will increase significantly to cover the impact of this selection. Indeed, in typical private insurance programs in which premiums are paid entirely by participants, the average cost for those who enroll will be well above the average of all potential applicants. As premiums are set higher to reflect the higher costs of enrollees, even fewer applicants are willing to pay them, further increasing selection effects and the average per enrollee cost.

The potential for adverse selection is even greater for a stand-alone Medicare prescription drug program because seniors can better predict their future drug costs than their other health care costs. The key to minimizing adverse selection in a Medicare prescription drug program is to increase participation rates, which can be accomplished through various means, including:

- **Premium subsidies.** When deciding whether to participate in the program, many seniors will evaluate the perceived value of the program and compare their expected out-of-pocket drug costs to the plan's premiums. Those who expect to have covered drug costs that are less than the premium required to participate will be less likely to enroll. Premium subsidies reduce the direct cost of participation, increasing the number of eligible individuals who will expect their likely benefit from the program to exceed the premium cost, and thus will increase enrollment.
- **"Default" enrollment.** Making enrollment in the drug program the default option (i.e., seniors desiring not to be in the program would have to take a step to opt out) would increase enrollment.
- **Penalty for delay.** Mandating that enrollment in the drug plan be on a guaranteed-issue basis would ensure that all seniors have access to the benefit, regardless of health status. However, these enrollment features could encourage seniors to delay enrollment until they expected to incur significant prescription drug expenses. Limiting guaranteed issue to an initial open enrollment period, or providing some other meaningful penalty for late enrollment, would encourage individuals with low current drug expenditures to consider their future needs and protect themselves by enrolling.
- **Risk Adjustment.** In the absence of universal coverage, some degree of adverse selection is inevitable. Risk adjustment and/or other types of reinsurance arrangements can reduce the incentives an insurer might have to avoid enrolling high-risk individuals. These options are discussed in more detail below.

The combination of these elements would help to reduce adverse selection, thereby increasing the program's long-term stability. In addition, because private insurers would hesitate to offer plans if they feared they would be selected against, reducing adverse selection would also increase the likelihood that insurers or other organizations would participate in the program.

Drug Utilization Management

The CBO estimates that prescription drug spending by the Medicare population will total $95 billion this year and will nearly triple to $284 billion by 2013. The introduction of a Medicare prescription drug program would likely increase drug spending even further due to induced or pent-up demand. In other words, because drug coverage would reduce the out-of-pocket costs of prescription drugs to consumers, they would be able to afford to use more drugs. One-third or more of seniors currently lack prescription drug coverage. Prescription drug spending by this population is very likely to increase dramatically if they obtain comprehensive drug coverage. Utilization could increase even among seniors with drug coverage (e.g., through a retiree health plan, Medigap, Medicare+Choice plan) if the Medicare prescription drug plan is more comprehensive than their current plan.

The long-term sustainability of a Medicare prescription drug plan depends in part on the extent to which the plan can manage drug utilization and spending. Many tools are available to help contain utilization and costs, including patient cost sharing, limiting the range of drugs covered, and drug utilization management mechanisms.

- **Patient cost sharing.** Patient cost sharing through deductibles, copayments, and/or coinsurance will reduce the overall cost of the program in two ways. First, it directly reduces the share of the costs borne by the insurance program. Second, and equally important, cost sharing will also make patients

more sensitive to prescription drug costs, thereby reducing utilization to that which is medically necessary and, ultimately, overall costs.

Deductibles are amounts that must be paid out-of-pocket before drug coverage begins. Aside from lowering the cost of benefits paid, low or modest deductibles help hold down administrative costs by eliminating claims processing for small amounts. Large deductibles in effect result in catastrophic coverage, which provides coverage for those most in financial need of assistance at a relatively low cost.

With *coinsurance*, the patient is responsible for a percentage of the drug cost. *Copayments*, on the other hand, are a fixed amount per prescription and have the advantage of being more predictable to patients. However, copayments might not make patients as sensitive to the costs of drugs as does coinsurance. Also, whereas coinsurance automatically adjusts for increases in drug costs, copayments (and deductibles) need to be increased periodically as drug costs rise, or overall program costs will increase faster than drug costs.

By making patients more sensitive to costs, cost sharing will decrease prescription drug utilization. Although the goal of cost sharing is to reduce unnecessary utilization, it will likely reduce necessary utilization to some extent as well. Reducing the cost-sharing requirements for lower-income seniors will help minimize the extent to which cost sharing discourages needed care. However, some minimal level of cost sharing should be present for even the lowest income levels to deter unnecessary utilization.

- **Formularies.** Formularies are lists of a plan's preferred medications and are used to encourage the use of less costly drugs. There are three types of formularies—open, closed, and incentive. Under *open formularies*, all drugs are available with no incentive to choose one over the other, although programs can be designed to encourage use of preferred medications (e.g. therapeutic interchange programs). In contrast, *closed formularies* limit the drugs available under the plan to those listed in the formulary. *Incentive-based formularies* contain cost-sharing differentials for preferred and non-preferred brand name drugs, and generic drugs, thereby giving patients a financial incentive to request preferred or generic medications. Nevertheless a non-preferred drug may be the only drug that is fully effective for a particular person, leaving the beneficiary paying more unless exceptions are available.

Merck-Medco, a pharmacy benefit manager (PBM), has estimated that the cost savings that derive from formularies can range from 2 percent to 3 percent for an open formulary with compliance interventions to 5 percent to 9 percent for a three-tier incentive-based formulary. It is important, however, that any formulary be broad enough to include drugs in each therapeutic category and class of covered outpatient drugs. In addition, the formulary must be periodically reviewed and modified to reflect new drugs being introduced and updated clinical information.

- **Drug Management Mechanisms.** Insurers and/or pharmacy benefit managers have several mechanisms they can use to help contain drug costs:

Prior authorization requires physicians to receive authorization that the drug is appropriate for the medical condition and could save from 1 percent to 2 percent of drug spending. Because it is expensive to administer, prior authorization is typically reserved for expensive drugs that have potential for excessive use or misuse.

Maximum dispensing limits restrict the quantity of medication a patient receives over time or per fill, and could also save about 1 percent to 2 percent of drug spending. This technique may be appropriate for therapies in which the potential for excessive use affects either cost or clinical outcomes.

Step therapies are used to check the medical appropriateness of using a newer, more expensive medication (i.e. a second-line drug) rather than a traditional medication (i.e. a first-line drug) for the same condition. This technique encourages the use of traditional therapies if they are more cost-effective than newer therapies and the new therapies offer minimal to no additional clinical benefit. Step therapies could save from 1 percent to 3 percent of drug spending.

Online drug utilization review can be performed electronically at the point of sale to ensure that the patient is eligible for the plan and that the prescription has not been refilled too soon. It can also screen for any drug interactions and perform other systematic checks. This concurrent review can save up to 4 percent of drug spending.

Risk Sharing

Many of the recent Medicare prescription drug coverage proposals suggest not only using private sector organizations to deliver the benefits, but also having these organizations share in the financial risk. Although private sector organizations have some experience with the risks associated with providing prescription drug coverage, either through employment-based, Medicare+Choice, or Medigap plans, these organizations lack experience with the overall senior market and there are increased risks associated with a new Medicare prescription drug benefit. In addition to adverse selection risks related to the program's overall participation rates, a Medicare prescription drug plan is also subject to risks associated with the difficulty in pricing the benefit adequately and plan-specific adverse selection. Each of these risks is discussed below, along with potential methods of addressing these risks.

Pricing Risk

It will likely be difficult for private sector organizations to estimate the per capita costs of a stand-alone prescription drug program for several reasons. First, the costs for seniors who are currently without drug coverage are uncertain. About one-third of current Medicare beneficiaries lack any prescription drug coverage. Their future prescription drug consumption will likely increase under a Medicare prescription drug benefit, but it is unclear how large that increase will be. Understating these costs could result in large losses to private sector entities. Overstating these costs could result in overpayments by the government.

Moreover, the lack of comprehensive data on current prescription drug usage by seniors makes it difficult to estimate costs under the program, even for those seniors who currently have prescription drug coverage. For instance, using cost estimates derived from Medigap plans could be unreliable. On one hand, these estimates could overstate costs due to the likely adverse selection from seniors who choose these plans. On the other hand, using spending data for seniors with relatively limited Medigap prescription drug coverage could understate costs under a more comprehensive prescription drug program. Because of the potentially enormous volume of senior drug spending, even a 10 percent misestimate in a single large State could cause a $100 million loss (or unexpected gain).

Not only is it difficult to accurately estimate initial levels of prescription drug spending, it is difficult to estimate the trends in spending. Drug spending among the nonelderly with employment-based coverage has grown recently, as much as 15 to 20 percent per year, due to a combination of higher drug prices, increased utilization, and the introduction of new and expensive drugs. On one hand, a Medicare prescription drug program that provides near-full coverage may have cost increases of that magnitude. On the other hand, drug utilization may not increase as quickly among the senior population if they are already using many drugs.

In order to mitigate the pricing risk issue, policymakers may wish to consider shared risk arrangements that protect the government from over-paying and provide protection for those organizations willing to participate. Risk corridors provide a mechanism to limit an organization's potential losses and gains to a more acceptable level. Reinsurance could also limit an organization's potential losses. In addition, using performance standards for administrative tasks in the first several years of a new Medicare prescription drug program could ease the transition to an insurance risk-based system. Each of these is discussed in more detail below.

- **Risk corridors** are contractual safeguards that can limit both the downside risk and upside gain for an insurance organization.[1] In a typical arrangement, a best estimate of the claims and administrative cost of a benefit would be made. Gains or losses inside a risk corridor around that estimated level would be the full responsibility of the private sector organization. Additional gains or losses beyond the risk corridor would be shared with or borne by the Federal Government. As a result, an at-risk organization such as an insurance company would be able to offer coverage, but its risk would be limited. The example below illustrates how risk corridors work:

Best estimate of annual Medicare prescription drug premium	$1,000 per year per senior
First-year Medicare prescription drug	±1 percent

[1] The Federal Government has large-scale experience with the use of risk corridors through its TriCare contracts, which provide health benefits to military personnel, their dependents, and military retirees. In addition, there are other risk corridors now being used in Medicare Private Fee For Service and PPO demonstrations.

risk corridor	(i.e., the corridor is 2 percent wide around the best estimate)
Dollars at risk per senior in first year	$10 per year per senior possible gain or loss
Federal Government responsibility	Losses in excess of $1,010 Gains if costs are less than $990 per year per senior

In this example, if the insurance company enrolled 1 million seniors, its maximum loss would be $10 million (1 million seniors times $10 maximum loss per senior), with the government covering any losses over $10 million. Similarly, if cost estimates proved to be conservative, then the Federal Government would recover any gains that exceeded $10 million.

Risk corridors or other risk-sharing arrangements might be essential during the first few years of a Medicare prescription drug program. During the period in which risk corridors are in place, both insurers and the Federal Government would be able to gather the drug expenditure data needed to make more accurate cost estimates for future years. As a result, this mechanism could be useful as a transition to full-risk contracting. (In the past, the Federal Government has had the time to conduct pilots or demonstrations on a small scale to gather the necessary beneficiary data, before implementing a new program. That time may not be available for a new Medicare prescription drug program.)

For example, in the second year, the risk corridor could be expanded from ±1.0 percent (a corridor 2 percent wide) to ±2.5 percent (a corridor 5 percent wide) to allow for greater incentives for the private sector organization. Other provisions could include some cost sharing (e.g., 10 percent) outside the corridor. In other words, the insurer would be responsible for all claims within the first 2.5 percent corridor, then 10 percent within an additional 5 percent corridor.

- **Aggregate Reinsurance** is another option to limit insurers' downside risk. Under aggregate reinsurance, the Federal Government would pay all or a percentage of claims once a private plan's aggregate claims paid exceed a predetermined threshold. This threshold is typically expressed as a percentage of aggregate expected claims (for example, a first-year aggregate limit might be 102 percent of projected paid claims). Insurers would keep all gains if actual claims are lower than expected. Government-provided aggregate reinsurance protection is similar to a one-sided risk corridor. In other words, the insurer would keep all gains, regardless of the size, if actual spending is less than expected, but would bear the losses only up to a certain point if spending is greater than expected. However, aggregate reinsurance may be easier to administer than risk corridors. Other mechanisms, like premium stabilization reserves, funded by some level of underwriting gains, could be added to limit the possibility of unintended funding windfalls.
- **Individual Reinsurance** can protect a plan from unexpected high claims from individual beneficiaries. Although there is much less variation in prescription drug spending among Medicare beneficiaries compared to other health spending, plans can still be at risk for unusually high claims among individual enrollees. Under individual reinsurance, the Federal Government would pay all or a percentage of claims once an individual enrollee's claims exceed a pre-determined threshold (typically expressed as a dollar amount, such as $7,500). Individual reinsurance, however, would not provide much protection for plans from higher than expected aggregate costs under the threshold, which could occur especially in the first few years of the program due to induced or pent-up demand.
- **Performance standards** are another approach that can be used to encourage cost containment. These measure plan administrators against certain criteria and require them to put a certain amount of administrative fees at risk for their performance. For example, a plan could have a negotiated goal that a certain percentage of prescription drug scripts be generic (e.g., 50 percent) in order to hold down costs. If this goal is met, then the Federal Government would provide the organization with its full administrative fee payment. Otherwise, a portion of the administrative fee payment would be forfeited. Again, such incentives might be particularly important during the first few years of program operation. After two or more years in this pilot state, the contract

could be converted into a full-risk contract, in which the organization would bear the insurance risk.

An important issue is the required duration of a risk corridor or reinsurance stage. Although prescription drug claims are typically paid much more quickly than other medical claims, sometimes within two to four weeks of being incurred, it is likely that any bidding process would require a pilot stage for the first two years. In year one, no data would be available to determine the best estimate of claim costs. Bidding for year two would begin almost immediately during the first year, so, once again, very little data would be available. By the second year of a contract, a full first year of data would be available and bidding for the third program year could proceed on an at-risk basis, or with a wider corridor.

Plan-Specific Adverse Selection

Even if adverse selection is minimized in the program as a whole, a particular plan could end up with a disproportionate share of seniors with high prescription drug expenditures. If payments to the plan do not reflect this, then the plan could be at risk for large losses. *Risk adjustment* could be used to adjust the payments to the plans to take into account the health status of the beneficiaries who participate in the program. Risk adjustment helps to make payments to competing plans more equitable and can reduce the incentives for competing plans to avoid beneficiaries with higher than average prescription drug needs. Risk adjustment may also help stabilize experience among private plans, causing less disruption for plan participants.

Several risk adjustment mechanisms for acute care services have been developed using pharmacy data. Pharmacy-based models can also be used as risk adjustment mechanisms for prescription drug utilization. Although risk adjustment can help account for the differences in participant health status across plans, no current risk adjustment system is designed to compensate each competitor for the full financial effects of adverse selection.

Conclusion

Proposals to add a prescription drug benefit to Medicare need to address issues related to adverse selection, drug utilization management, and risk sharing. Adverse selection will be minimized to the extent that participation is nearly universal. This can be accomplished through high premium subsidies, default enrollment, and penalties for delayed enrollment.

The long-term sustainability of a Medicare prescription drug program also depends on the extent to which the program manages drug utilization and spending. Patient cost sharing, formularies, and other drug management mechanisms can each help contain costs.

Finally, policymakers may want to provide provisions to minimize the financial risk of private sector organizations administering or delivering the benefit in the first few years of the program. Risk corridors, reinsurance, and performance standards could be used in the initial years of a prescription drug program while organizations collect important data. Risk adjustment could provide additional protection to private organizations, thereby increasing their willingness to participate.

Statement of David G. Schulke, Executive Vice President, American Health Quality Association

The American Health Quality Association represents independent private organizations—known as Quality Improvement Organizations (QIOs)—that work under contracts with the Centers for Medicare and Medicaid Services (CMS) to improve the quality of care for Medicare beneficiaries in all 50 States and every U.S. territory. Congress created the QIOs to monitor and improve the quality of care delivered to Medicare beneficiaries and supports the national work of the QIOs with approximately $333 million annually from the Medicare Trust Fund, or about $8 per beneficiary per year.

Past policy efforts to develop a Medicare prescription drug benefit for the 21st century have focused almost exclusively on financing a benefit. Very little attention was given to including initiatives in the drug benefit to ensure a benefit is safe and continuously monitored to maximize the quality of outpatient pharmacotherapy.

It is absolutely critical to create an integrated quality improvement program. Otherwise, beneficiaries are likely to be ill-served by a carved-out drug benefit that op-

erates separately from the Medicare hospital and outpatient benefits and data systems.

Building a Safe Drug Benefit.

A Medicare outpatient prescription drug benefit presents an opportunity to improve the quality of life for our nation's seniors, but also brings the real risk of increased morbidity and mortality associated with an increase in the use of medications. It is reasonable to predict that with an outpatient prescription drug benefit, more seniors will receive more drugs. Expanding access to and availability of drugs, without a complementary investment in quality improvement, will exacerbate the unacceptable cost and incidence of hospital and long-term care admissions associated with medication use. A recent meta-analysis of 11 different studies reviewing drug use in the elderly population found that "[t]he reported prevalence of elderly patients using at least one inappropriately prescribed drug ranged from a high of 40% for a population of nursing home patients to 21.3% for community-dwelling patients over age 65." [i]

Pharmacoeconomists at The University of Arizona have tracked the costs associated with drug therapy since the early 1990s.[ii],[iii] In the spring of 2001 these researchers published the following statement: "Overall, the cost of drug-related morbidity and mortality [in the ambulatory care environment] in the United States exceeded $177.4 billion in 2000. Hospital admissions accounted for nearly 70% ($121.5 billion) of total costs, followed by long-term-care admissions, which accounted for 18% ($32.8 billion)." [iv]

Integrating Medical and Pharmacy Data Systems through Medicare QIOs.

Historically, attempts to address the morbidity and mortality associated with medication use have been stymied by the inability of practitioners in various disciplines to access certain medical or pharmacy records that would otherwise provide a comprehensive picture of a patient's true medication use history. As this Committee discusses building a Medicare prescription drug benefit for the 21st century, it is essential that the new statutes and regulations include language that provide the QIOs with access to pharmacy claims data. Regardless of how a drug benefit is administered, the Secretary of HHS must have unrestricted access to pharmacy claims data to use in directing the activities of the QIOs. QIOs were created by Congress with the necessary confidentiality protections and staff expertise to permit them to combine medical and pharmacy data to guide health care systems improvement.

Most congressional proposals forwarded to date rely on the pharmacy benefit administrators to process pharmacy claims data and take certain quality improvement steps at the point of service when the pharmacy claims data suggests medication misadventures. The good work of the pharmacy benefit administrators is limited by the information present in the pharmacy claim. Without integration of the data present in the medical record and pharmacy record, systematic failures leading to inappropriate prescribing and dispensing will continue to happen everyday.

Integration of Data Systems through QIOs Is Critical—A Study of Outpatient Beta-Blocker Use in Heart Attack Victims.

QIOs use data to track progress and improve provider performance, reducing errors by focusing on treatment processes, mostly pharmacotherapy. Since 1996, QIOs have worked on local projects to improve clinical indicators in care for diseases and conditions that broadly afflict seniors. Among the diseases targeted for quality improvement by the QIOs, treating heart attack victims with beta-blockers offers an example of how the QIOs could further their current inpatient efforts with appropriate access to data gathered with an outpatient prescription drug benefit.

Medical practitioners have known for several decades that the secondary prevention benefits of beta-blocker therapy after heart attack include reduced hospital readmissions, reduced incidence of further heart attacks, and decreased overall mor-

---

[i] Lui GG, Christensen, DB, "The Continuing Challenge of Inappropriate Prescribing in the Elderly: An Update of the Evidence." *J Am Pharm Assoc,* 42(6), p847–857, 2002.

[ii] Johnson JA, Bootman JL, "Drug-related morbidity and mortality. A cost-of-illness model." *Arch Intern Med (United States)*, 155(18), p1949–56, 1995.

[iii] Harrison DL, Bootman JL, Cox ER. "Cost-effectiveness of consultant pharmacists in managing drug-related morbidity and mortality at nursing facilities." *Am J Health Syst Pharm*, 55(15), p1588–94, 1998.

[iv] Ernst FR, Grizzle AJ, "Drug-related morbidity and mortality: updating the cost-of-illness model." *J Am Pharm Assoc*, 41(2), p191–199, 2001.

tality.[v] The evidence is so convincing that the American College of Cardiology and the American Heart Association guidelines for the management of heart attack recommend routine beta-blocker therapy for all patients without a contraindication.[vi] Despite the evidence and expert recommendations, the use of beta blockers after heart attacks remains considerably suboptimal, with 20–30% of appropriate patients lacking this essential therapy.[vii] The reason is unlikely to be cost. Beta-blocker therapy in the outpatient setting is one of the most affordable medications available to patients. A 90-day supply of this life-saving medication usually costs less than $10.00.

QIOs work to ensure that patients discharged from the hospital following a heart attack leave the hospital with a prescription for a beta-blocker. In the November 2002 issue of the *Journal of the American College of Cardiology (JACC)*, researchers report that many patients never fill prescriptions for their discharge medication, and many of those that do discontinue the use of beta-blockers shortly after filling the prescription. The study's authors conclude: "Patients not discharged on beta-blockers are unlikely to be started on them as outpatients. For patients who are discharged on beta-blockers after AMI, there is a significant decline in use after discharge. **Quality improvement efforts need to be focused on improving discharge planning and to continue these efforts after discharge**."[viii] During the QIO's Sixth Scope of Work (1999–2002), QIOs were responsible for improving the national rate of beta-blocker order at discharge by 7%.[ix]

In his study published in *JACC*, Butler and colleagues found that the first step to preventing heart attack recurrence is to make sure a prescription is written and ordered at the time of the patient's discharge from a heart attack hospitalization. If this is done, the study shows there is a 10 TIMES greater likelihood of getting that patient started on inexpensive, effective beta blocker drugs that 20–30% of Medicare heart attack patients still do not receive, almost 40 years after the first marketing of propranolol, the first beta blocker.

The authors of the study utilized data for the dually enrolled population of patients (those receiving Medicare and Medicaid benefits simultaneously), as this is the only population of seniors for which there is comprehensive drug therapy claims data. This same kind of monitoring should be available for all beneficiaries. It is critical for Medicare to have the drug claims/utilization data so QIOs can identify heart attack patients who don't fill a prescription for beta blockers post discharge, or who stop filling prescriptions (almost one quarter do after 6 months, according to the study)—and give their physicians assistance in getting the prescription started or changed (the latter might be needed if the patient didn't like the particular beta blocker initially prescribed and has consciously stopped taking it due to unacceptable or intolerable side effects). QIOs are ideally suited to identify patients at highest risk for hospital readmission or death due to poor beta-blocker adherence (i.e., patients taking beta-blockers post heart attack). We believe the QIOs unique ability to integrate medical information with pharmacy claims/utilization data complement pharmacy adherence programs that may be currently managed by benefit administrators.

QIO Confidentiality Requirements.

The confidentiality of information collected or developed by a Medicare QIO is assured by Section 1160 of the Social Security Act. It was the intent of Congress in drafting this provision to provide safeguards for information identifying a specific patient, practitioner or reviewer. These safeguards foster an environment that is conducive to quality improvement efforts.

---

[v] Soumerai, SB, McLaughlin TJ, et al. "Adverse outcomes of underuse of beta-blockers in elderly survivors of acute myocardial infarction." *JAMA*, 227, p115–121, 1997.

[vi] Ryan TJ, et al. "ACC/AHA guidelines for the management of patient with acute myocardial infarction. A report of the ACC/AHA Task Force on Practice Guidelines (Committee on Management of AMI)." *J Am Coll Cardiol*, 28, p328–348, 1996.

[vii] Krumholz HM, et al. "National use and effectiveness of beta-blockers for the treatment of elderly patients after AMI: National Cooperative Cardiovascular Project." *JAMA*, 280, p623–629, 1998.

[viii] Butler J, et al. "Outpatient adherence to beta-blocker therapy after AMI." *J Am Coll Cardiol*, 40(9), 1589–1595, 2002.

[ix] Jencks SJ, et al. "Change in the Quality of Care Delivered to Medicare Beneficiaries 1998–1999 to 2000–2001." *JAMA*, 289, p305–312, 2003.

Recommendations.

The American Health Quality Association has drafted the following legislative specifications we ask the Committee to include in this year's Medicare outpatient prescription drug benefit bill.

Legislative Specifications for the 108th Congress.

1) Give the QIOs responsibility for the outpatient drug benefit analogous to the responsibility they have for all other Title 18 benefits:

Add new 'Sec ____. Review Authority—. Section 1154(a)(1) is amended by adding 'and section ____ after '1876'.

2) Instruct the QIOs to make assistance available to providers, practitioners and benefit administrators to improve the quality of care under the new drug benefit.

Prescription Drug Therapy Quality Improvement.—Section 1154(a) is amended by adding a new paragraph 17:

"(17) With respect to items and services provided under Title XVIII Part ____ the organization shall execute its responsibilities under subsection (a)(1)(A) and (B) by making available to providers, practitioners and benefit administrators assistance in establishing quality improvement projects focused on prescription drug or drug-related therapies. For the purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function."

3) Include legislative language instructing prescription drug benefit administrators to provide patient specific pharmacy claims and drug utilization data to the Secretary of HHS. Suggested wording:

"Requirements for Prescription Drug Plan Sponsors, Contracts, Establishment of Standards.—Any agreement between the Secretary and a benefit administrator for this purpose shall provide the Secretary with all patient specific pharmacy claims and drug utilization data."

4) Include legislative language providing appropriate availability of prescription drug claims data to the QIOs for quality improvement purposes. Suggested wording:

"Data Availability.—The Secretary shall provide the utilization and quality control peer review organizations with the patient specific pharmacy claims and drug utilization data to permit the organizations to perform the functions described in 1154(a)(17)."

Long Term Care Pharmacy Alliance
Washington, DC 20037
April 8, 2003

The Honorable William M. Thomas
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth H.O.B.
Washington, DC 20515

Dear Chairman Thomas:

On behalf of the Long Term Care Pharmacy Alliance, I am writing to submit this statement for the record of your Committee's April 9, 2003 hearing on "Expanding Coverage of Prescription Drugs in Medicare."

We appreciate your leadership in considering issues related to the creation of a new Medicare prescription drug benefit, and we would like to take this opportunity to highlight the special pharmacy needs of the nation's frail elderly residing in nursing facilities. We want to work constructively with you to ensure the continued provision of quality services to these particularly vulnerable seniors.

While most Medicare beneficiaries are able to walk into pharmacies to pick up their prescriptions or to receive vials of pills through the mail, a sizable percentage of beneficiaries cannot do so and need special services that retail and mail order pharmacies do not provide. Nursing home residents have specific diseases and multiple co-morbidities that require specialized pharmacy care. Without such treatment, we cannot expect positive therapeutic outcomes for these patients. Failure to take

into consideration the special pharmacy needs of the frail and institutionalized elderly will lead to a marked increase in medication errors and other adverse events.

Pharmacy benefit managers and insurance companies are not equipped to administer a Medicare drug benefit to this vulnerable population, because they lack the necessary experience, infrastructure and expertise. By contrast, members of the Long Term Care Pharmacy Alliance are the nation's major operators of pharmacies that serve the frail and institutionalized elderly, and they specialize in serving the needs of patients in long-term care settings.

LTCPA members' patients are elderly, frail, chronically ill, and can no longer care for themselves. They require a level of pharmacy care that goes well beyond what the typical retail or mail order pharmacy provides to its customers. To meet these needs, long-term pharmacies provide specialized packaging, 24-hour delivery, intravenous and infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are indispensable in the long-term care environment.

Without ensuring that nursing-home residents and other patients with special needs can receive these specialized pharmacy services, a Medicare prescription drug benefit could actually endanger the health of beneficiaries residing in nursing facilities. We look forward to working with you on a specific proposal to ensure appropriate coverage of pharmaceutical services for Medicare beneficiaries who reside in nursing homes.

If you have any questions or would like additional information, please feel free to contact me at (202) 457–6000. Thank you for your consideration of our views.

Very sincerely yours,

John F. Jonas

cc: The Honorable Charles B. Rangel
The Honorable Nancy L. Johnson
The Honorable Fortney H. Stark

Statement of the National Association of Chain Drug Stores, Alexandria, Virginia

Mr. Chairman and Members of the Subcommittee. The National Association of Chain Drug Stores (NACDS) is pleased to submit this statement for the hearing on *Designing a Medicare Prescription Drug Benefit for the 21st Century*.

NACDS represents over 200 pharmacy companies that operate nearly 35,000 community-based retail pharmacies. NACDS members employ nearly 100,000 pharmacists and provide about 70 percent of all outpatient prescriptions. The majority of our prescriptions are paid for by third party insurance companies and pharmacy benefit managers—over 85 percent—so we have a significant amount of experience in operating in the current pharmacy benefit marketplace. Our industry and the patients that we serve will be significantly affected by the structure and operation of any new Medicare pharmacy benefit. For that reason, we need to be engaged and involved in the policy discussions regarding a Medicare pharmacy benefit. We believe that we can provide a unique perspective on what we feel will work best for Medicare program, seniors, and the taxpayers.

Principles for a 21st Century Medicare Pharmacy Benefit

It is often said that no one would design a contemporary Medicare program without a prescription drug benefit. We agree. Prescription medications are the most widely used and cost-effective health care interventions used by patients today. Modern prescription drugs have extended and improved the lives of millions of Americans and saved millions of dollars through shortened length of illnesses, increased productivity, and reductions in hospitalization and medical procedures. Community pharmacy is proud of its role in assuring the safe and effective use of these therapies.

That is why we believe that any new program to expand prescription drug coverage to seniors should be a pharmacy benefit, not just a prescription drug benefit. Too often, we think of a prescription drug benefit as only providing a "drug product" to seniors. We believe that this is a serious mistake. Seniors take so many more prescription medications than younger individuals. For that reason, seniors need ready access to community-pharmacy-based education, counseling, and medication therapy management, in addition to the drug product, so they can take their medications appropriately to achieve the intended medical outcomes.

NACDS, along with seven other national pharmacy and related organizations, developed principles for and components of a quality, cost-effective pharmacy benefit. Among other items, pharmacy believes that the best way to develop the Medicare

pharmacy benefit for the 21st century would be to incorporate the following elements:

- Create transparency and full pass through of any rebates, discounts, or other price concessions received by administrators of the pharmacy benefit so that Medicare and seniors benefit from their purchasing power;
- Include policies that promote the utilization of generic drugs when appropriate;
- Provide seniors with access to meaningful, community-based medication therapy management services with appropriate compensation for pharmacies;
- Give seniors access to the community-based pharmacy provider of their choice;
- Break down any artificial barriers created by drug plan administrators that impede competition and steer patients to higher-cost brands or limit their choice of pharmacy provider;
- Do not economically coerce seniors to use other prescription delivery mechanisms, such as out-of-state mail order;
- Assure that community pharmacies are adequately compensated in providing services to meet the health care needs of our nation's seniors.
- Allow the intense competitive forces that exist among pharmacies and manufacturers to work to reduce costs without the interference of a self-interested middleman.

We believe that these are among the most important principles that can be included in any future pharmacy benefit. We also want to describe for the Subcommittee some observations about trends in the marketplace that are important to consider as the Medicare pharmacy benefit debate moves forward.

FEHBP and DOD Use Different Approaches to Prescription Drug Benefit Design

The Federal Employees Health Benefits Program (FEHB) is often pointed to as the model for Medicare reform. Frankly, we believe that a more careful examination of the prescription drug benefit programs in FEHBP will give policymakers ample evidence to re-evaluate some of the major models being proposed that would rely primarily on pharmacy benefit managers (PBMs) to provide a prescription drug benefit.

Anyone who is following the health policy, business, and financial news would find that important public health and public policy questions are being raised about the current practices of PBMs, and whether they are holding down drug costs, or responsible, in part, for their significant increases.

The experience of the government's own FEHBP should be instructive to Members of Congress as they consider the true effectiveness and competitiveness of this approach to providing a prescription drug benefit for seniors. Our analysis indicates that escalating prescription drug spending in the FEHBP program—which is administered by some of the same PBMs that would be used for Medicare—has contributed significantly in recent years to the sharp premium increases seen in the program. In fact, these PBMs have a poor track record in managing FEHBP drug program costs. For example, the Office of Personnel Management's (OPM) own data indicate that drug cost increases were responsible for 40 percent of the 10.5% premium increase in 2001, 37 percent of the 13.3% premium increase in 2002, and 30 percent of the 11.1% premium increase in 2003.

Keep in mind that the average age of the FEHBP population is about 47 years of age, while that of traditional older Medicare population is about 70. Medicare beneficiaries have more chronic conditions, requiring greater drug use, which results in higher per capita expenditures than the much-younger, healthier FEHBP population. For example, the average Medicare beneficiary uses four times more prescriptions—about 21 prescriptions each year—than the average individual under 65 years of age, who uses about 5. If the PBMs have not been able to manage prescription drug spending in the FEHBP program's younger, healthier population, why should we believe that they would be any more effective in the higher-cost Medicare population?

A recent General Accounting Office (GAO) report[1] found that PBMs would not disclose the amount of rebates and other price concessions that they receive from drug manufacturers. These price concessions take many forms and have many different names. The bottom line is that the Medicare programs, seniors, and tax-

[1] GAO Report on Federal Employees' Health Benefits: *Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, January 2003.

payers should benefit from these financial incentives, and the best way to assure that they are passed along is to require transparency in their reporting by the PBMs. We urge that such provisions be included in any final Medicare pharmacy benefit program.

PBMs' Anti-Competitive Practices Not Aligned with Goals of Payors or Medicare

Any Medicare pharmacy benefit for the 21st century should emphasize choice and access. These goals can only be attained if the structure of the pharmacy benefit breaks down many of the artificial, anti-competitive barriers erected by the PBMs. Many public and private payors are rethinking their PBM strategies because they recognize that PBMs have overpromised and underdelivered. The goal of payors to reduce prescription drug costs is not necessarily aligned with that of the PBMs, which is to drive manufacturers rebates to gain higher operating profits for the PBM. These rebates are generated by promoting the use of higher-cost brand name drugs. What follows is an excellent example of how rebates create perverse incentives and anti-competitive practices in the marketplace:

Most PBM-administered prescription drug benefit plans have both a community retail pharmacy network and a mail order pharmacy component (i.e. Medco, Express, Advance PCS, Caremark). In most cases, these mail order pharmacies are owned by the PBM, and the PBM uses the patient-identifiable information that they obtain from processing a retail pharmacy claim, to switch patients to their own mail-order facilities.

The PBMs have financial incentive to do this because they receive significant rebates from brand name manufacturers for moving (or increasing) a particular manufacturer's market share, so the more product that is dispensed through mail, the more rebates the PBM receives. This is not always cost-effective for the payor or the patient, since it increases copays for the patient and overall costs for the payor. Moreover, the retail pharmacy doesn't receive rebates and has no incentive to provide higher-cost brand name drugs.

In fact, retail pharmacies use more lower-cost generics than mail, so the net cost to the payor and the patient is actually lower for drugs dispensed through retail. (Latest data found that mail order uses 37% generics, while retail uses generics in 49% of the cases).

But, to force patients to obtain their brand name drugs through mail, these PBMs artificially limit the quantity of brand name drugs that a retail pharmacy can dispense.

That is, while PBMs may incorrectly contend that State pharmacy practice laws prohibit retail pharmacies from dispensing a 90-day supply of medications, this is not the case. Some States do have limits on the amount of controlled substances that can be provided, but these restrictions would occur for any pharmacy outlet that dispenses these drugs. PBMs, however, will not allow pharmacies to provide any more than a 30-day supply because they want to run those prescriptions through their mail order facility so they can collect the manufacturer rebates.

Mail order operations are direct competitors to community pharmacies. PBMs should not be allowed to use information obtained through a retail prescription claims transaction to switch patients to mail order for their own financial gain. To avoid this anti-competitive practice, PBMs should not be allowed to be both the community pharmacy network contractor and mail order contractor within the same region, since this creates a competitive conflict with community retail pharmacies. In addition, pharmacies should be allowed to continue to provide maintenance medications to patients (i.e. fill a 90-day supply of maintenance medication). PBMs should not contractually prohibit pharmacies from providing these medications. PBMs should not use any coverage or cost sharing incentive that would create incentives for seniors to use one method of pharmacy distribution over another.

Some of these anti-competitive issues can be addressed by including strong "transparency" provisions in the Medicare pharmacy benefit. Pricing transparency is necessary for the efficient operation of markets, and also allows consumers and others to make the best purchasing choices. Right now, the PBM industry is operating without this necessary transparency.

The Medicare program and seniors should benefit directly from any and all price concessions given to plan administrators and PBMs. These price concessions take many forms—rebates, discounts, formulary placement fees, market share movement fees, data collection and analysis fees, and others.

If made transparent, and passed along, these incentives will ultimately reduce the cost of the benefit to Medicare and to seniors. It will also reduce the incentives that

PBMs have to erect these anti-competitive barriers that increase cost and can negatively impact quality of care.

The PBM industry argues against transparency because they know it will more fully expose that their business model centers almost exclusively on deriving and retaining rebates from drug manufacturers that are not passed along to plan sponsors. We urge policymakers to make sure that transparency is a hallmark of any Medicare pharmacy benefit.

Department of Defense (DOD) Recognizes PBM Influences

In contrast to the FEHBP program, which relies on private sector PBMs, the DOD's Tricare program has developed prescription drug models that are more cognizant of the negative influences of PBM rebates. Their approach uses a pharmacy benefits administrator (PBA) type model, which is the approach being taken by more and more public and private sector payors.

The PBA model relies on a benefits administrator to adjudicate and pay claims, determine eligibility, create networks, and perform other operational functions to run the program. The PBA doesn't become involved with direct rebate negotiations with manufacturers, and is therefore not in a position to retain these rebates or develop policies that would encourage the dispensing of drugs for which they are receiving rebates.

For example, the Tricare National Mail Order Program (NMOP) program passes along to DOD all the rebates that the DOD negotiates with pharmaceutical companies. This program is administered by Express Scripts, so even the traditional PBMs are able to participate in models that use PBA-type approaches. Building on the success of the NMOP program, DOD recently announced that its Tricare national retail pharmacy contract would operate in a similar manner. The DOD has recognized that PBMs retain a significant portion of manufacturer rebates and want these rebates to accrue to the DOD and the military eligibles and retirees. Thus, there are two major Federal Government health care programs using different approaches—with very different outcomes—to provide pharmacy benefits to two important populations.

NACDS and community pharmacy support approaches to delivering a Medicare pharmacy benefit that take the perverse rebate incentives out of the system, since it results in nothing more than limiting seniors' access to needed medications and the pharmacy of their choice.

Medicare, seniors, and taxpayers would all benefit from a system where any manufacturer or pharmacy price concessions are passed along to the senior, and anti-competitive incentives to dispense larger quantities of brand name medications or restrict the use of generics are eliminated.

Marketplace Has Responded with Discounts for Low-Income Seniors

We believe that the market has changed significantly since the Department of Health and Human Services (HHS) announced its original Medicare-endorsed PBM-based discount card program in July 2001. For example, manufacturers now offer prescription drug assistance through participating retail pharmacies. These programs include "Lilly Answers," "Pfizer's Living Share Program" and the "Together Rx Program" all of which assure that truly needy low-income seniors are able to obtain meaningful savings on brand name prescription medications at their participating local pharmacy.

These private-sector approaches obviate the need for government-mandated programs on the private sector. Over 150 brand name prescription drugs are available at discounts of up to 40 percent. In fact, the best competition occurs in the market when manufacturers and pharmacies compete without the interference of a middleman PBM that has the government's sanction to create artificial barriers to competition in the marketplace.

By HHS' own estimate, their Medicare-endorsed PBM-based discount card program, such as those envisioned by CMS, would only generate savings of 10 to 13 percent for seniors on the cost of their prescriptions. Almost all of these savings would come from reduction in the prices that pharmacies charge, not a reduction in the price that the manufacturer charges the pharmacy for the drug. Moreover, these discount card programs—which already exist in the market—overuse higher-cost brand name drugs, rather than lower-cost generics. That is because PBMs earn rebates from drug manufacturers by promoting the use of their brand name drugs. These practices lead to higher prescription drug bills for seniors, not lower ones.

Under a Medicare-endorsed discount card program, seniors' access to needed prescription medications and their choice of pharmacy would be restricted. Under these other newer programs, however, seniors do not have to make choices between var-

ious discount programs, switch their medication from a drug they may be taking to another drug just to get a discount, and don't have to give up using their local pharmacy. In our opinion, this is better health care for seniors.

We would ask that you reconsider your approach to legislating a Medicare-endorsed discount card program that would be of little benefit to seniors and would significantly harm community pharmacies. Instead, we ask that you work with us to assure that private-sector approaches continue to be developed, which will help seniors obtain their prescription medications in the short term, while we work on a model for longer term Medicare reform that incorporates these important private-sector approaches.

Conclusion

NACDS believes that the Subcommittee is asking the right questions regarding the best way to structure a Medicare prescription drug benefit that will serve the needs of Medicare beneficiaries and pharmacies in the 21st century. Contrary to popular opinion, today's market for prescription drug benefits has structural flaws that are being recognized by many public and private payors as impeding competition and unnecessarily increasing costs. These payors are responding by taking their benefit management functions in house, or by using a pharmacy benefits administrator (PBA) model. We believe that any pharmacy benefit should rely on the competitive market forces that already exist among pharmaceutical manufacturers and retail pharmacies, and that artificial barriers should not be erected to impede this competition.

The Committee should also take note of the market shift that appears to be occurring—both in private and public sector programs—away from PBM models and toward PBA or in-house administration models. These approaches help assure that the plan sponsors reap the benefits of their purchasing power, rather than having it diluted by a middleman.

In order to provide the most competitive pharmacy benefit possible, policymakers should assure that the following components are incorporated into the program: 1) transparency and pass through of all PBM-derived rebates, concessions, and discounts; 2) assurances that PBMs do not erect artificial barriers to seniors' access to the pharmacy of their choice, such as through restrictive networks, limitations on the quantity of medication that retail pharmacies can provide, or differential cost sharing to provide seniors with incentives to use mail order over retail pharmacies; 3) limits on the activities performed by PBMs so that they function more as PBAs, and do not become involved in patient care functions, which is the purview of the health professionals; and, 4) restrictions on the ability of the PBM to serve both as the retail network administrator and the mail order provider in the same region, which is an inherent conflict of interest since PBMs are direct competitors of retail pharmacies.

NACDS and its member companies look forward to working with the Subcommittee and full Committee on developing this Medicare pharmacy benefit. Thank you for an opportunity to submit this statement.